Supreme Court, U.S.
FILED

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No. OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1994

COMBINED MANAGEMENT, INC.,

Petitioner,

v.

BRIAN K. ATCHINSON, In His Representative Capacity As Superintendent, Bureau of Insurance of the State of Maine,

Respondent.

On Petition For Writ Of Certiorari To The United States Circuit Court Of Appeals For The First Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Assuming, arguendo, that the employee benefit plan of the International Association of Entrepreneurs of America ("IAEA"), through which the Petitioner Combined Management, Inc. ("CMI") allegedly provides a variety of benefits to its employees is a so-called Employee Retirement Income Security Act ("ERISA") benefit plan, *whether* the funding requirements of the Maine Workers Compensation Act (39-A M.R.S.A. § 403) are preempted by § 514(a) of ERISA (29 U.S.C. § 1144)?

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 28.1, Petitioner hereby states that it is a privately owned corporation in which no outside persons have an interest, and it has no parent or subsidiary corporations.

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OPINIONS BELOW

The decision of the United States Court of Appeals for the First Circuit was rendered on April 22, 1994. That decision is reported at 22 F.3d 1 and is reproduced at page 1a of the Appendix to the Petition for Certiorari ("Pet. App. 1a").

The decision of the United States District Court was rendered on August 2, 1993, affirming the recommended decision of the United States Magistrate Judge dated June 15, 1993. A copy of the United States District Court decision is

an unreported case and is reproduced at Pet. App. 19a. The recommended decision of the United States Magistrate Judge is unreported and is reproduced at Pet. App. 21a.

JURISDICTION

The decision of the United States Circuit Court of Appeals was issued on April 22, 1994. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1) (West 1993). The jurisdiction of the United States District Court was invoked pursuant to 29 U.S.C. § 1451(c) (West 1990, West Supp. 1993).

STATUTES INVOLVED

This case involves certain provisions of ERISA, including § 514(a)(C), 29 U.S.C. § 1144(a)(C) (West 1990, West Supp. 1993) (Pet. App. 137a) which provides in relevant part as follows:

> **(a) Supersedure; effective date**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.
>
> * * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefits plans covered by this subchapter.

and ERISA § 4(b)(3), 29 U.S.C. § 1003(b)(3) (West 1990) (Pet. App. 134a-135a) which provides in relevant part as follows:

(b) The provisions of this subchapter shall not apply to any employee benefit plan if –

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;

ERISA defines "employee benefit plan" at ERISA § 3(1), 29 U.S.C. § 1002(1) (West Supp. 1993) as follows:

§ 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the

> extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

In addition, this case involves certain provisions of the laws of the State of Maine, including 32 M.R.S.A. § 14055(1)(B) (West Supp. 1993) (Pet. App. 151a) which provides in relevant part as follows:

> **§ 14055. Insurance; unemployment insurance; benefit plans**
>
> **1. Benefits.** The following provisions govern the provision of benefits by employee leasing companies to their employees . . .
>
> **B.** The superintendent shall adopt rules governing the provision of workers' compensation insurance as required by Title 39-A, chapter 9 for workers provided by an employee leasing company to any client company. These rules must be consistent with subsection 2 and reflect consideration of the needs and operational efficiencies of employee leasing companies and the costs to the workers' compensation system.

and certain provisions of the Maine Workers' Compensation Act, 39-A M.R.S.A. §§ 401, 403 (West Supp. 1993)

(Pet. App. 156a, 163a) which provide in relevant part as follows:

> **§ 401. Liability of employer**
>
> **1. Private employers.** Every private employer is subject to this Act and shall secure the payment of compensation in conformity with this section and sections 402 and 407 with respect to all employees, subject to the provisions of this section. . . .
>
> **§ 403. Insurance by assenting employer; requirements as to self-insurers.**
>
> An employer subject to this Act shall secure compensation and other benefits to the employer's employees in one or more of the ways described in this section. . . .
>
> **1. Insuring under workers' compensation insurance policy.** The employer may comply with this section by insuring and keeping insured the payment of such compensation and other benefits under a workers' compensation insurance policy. . . .
>
> **2. Pilot projects.** Workers' compensation health benefits pilot projects are authorized under the following provisions.
>
> > **A.** The Superintendent of Insurance shall adopt rules to enable employers and employees to enter into agreements to provide the employees with health care benefits covering workplace injury and illness and nonworkplace injury and illness and other health care benefits in comprehensive pilot projects. The health care benefits may be provided by: organizations authorized to do business under Title 24; insurers or health maintenance organizations authorized

> to do business under Title 24-A; employee benefit plans; and benefit plans of employers who self-insure under this section. The superintendent shall review all pilot project proposals and may approve a proposal only if it confers medical benefits upon injured employees substantially similar to benefits available under this Title. The superintendent shall revoke approval if the pilot project fails to deliver the intended benefits to the injured employees.

Maine Administrative Regulation: Maine Bureau of Insurance, Rule 560 promulgated by the Maine Bureau of Insurance states the duty of employee leasing businesses to provide workers' compensation benefits, and Rule 560 states in relevant part as follows:

> **§ 560**
>
> **Section 4. Eligibility for Policy Issuance and Continuance**
>
> A. Basic Rule.
>
> Except as provided in Subsection B, a lessee, not authorized to self-insure pursuant to 39 M.R.S.A. §23 [39-A M.R.S.A. § 403], shall fulfill its statutory responsibility to secure benefits under the Workers' Compensation Act by purchasing and maintaining a standard workers' compensation policy approved by the Superintendent of Insurance. The exposure and experience of the lessee shall be used in determining the premium for policy.
>
> B. Exceptions

> A lessor which obtains coverage in the voluntary workers' compensation market and is registered with the Superintendent of Insurance, pursuant to 32 M.R.S.A. §14052, may, with the voluntary market insurer's knowledge and consent, elect to secure the coverage on leased employees through a standard workers' compensation policy issued to the lessor. The insurer of the lessor may take all reasonable steps to ascertain exposure under the policy and collect the appropriate premium . . .

See, Pet. App. 198a.

STATEMENT OF THE CASE

This case challenges the right of the State of Maine to require a private employer to establish and maintain a separately funded employee benefit plan solely for the purpose of complying with the Maine Workers' Compensation Act or, alternatively, to submit the private employers' fully integrated, multi-benefit plan to State regulatory control. The employer contends that such State requirements and prohibitions are preempted by ERISA, 29 U.S.C. § 1144(a) (West 1990, Supp. 1993).

The Petitioner Combined Management, Inc. ("CMI"), is a Maine corporation which has been engaged since January 10, 1992, in the business of employee leasing pursuant to 32 M.R.S.A. § 14051, et seq. (West Supp. 1993). See, Affidavit of Richard Spugnardi,¶2-3 ("Spugnardi Aff."), at Pet. App. 33a. Employee leasing business or

their client businesses are required to provide the workers' compensation benefits mandated by the Maine Workers' Compensation Act, 39-A M.R.S.A. § 101, et seq. (West Supp. 1993).

Since January, 1993, CMI has provided such benefits by membership in the International Association of Entrepreneurs of America ("IAEA") and participation in the IAEA Employee Welfare Benefit Plan and Trust offered by the IAEA (respectively, the "IAEA Plan" and the "IAEA Trust"). See, Spugnardi Aff. ¶4-9 at Pet. App. 33a-35a. The IAEA Plan provides, *inter alia*, that the employees of participating Employers shall receive "occupational injury and illness benefits at levels commensurate with the workers' compensation laws" of the State of Maine. See, IAEA Plan, Article 18, Pet. App. 93a; Spugnardi Aff. ¶¶9 and 16 at Pet. App. 34a, 36a.

The IAEA Plan is self-funded and self-adjusting. That is to say, the participating employers operate the IAEA Plan and are assessed currently for the cost of the operation of the IAEA Plan as well as for the funding of the IAEA Trust which provides the benefits. Funding is based upon actuarial assumptions and formulae. The IAEA Plan and the IAEA Trust are reinsured pursuant to an insurance treaty with an independent insurance company. IAEA takes the position that the IAEA Plan and IAEA Trust provide only reimbursement of expenses incurred by employees through an ERISA Plan. Therefore, IAEA is not an insurer and has not applied to do business in Maine as an insurance company.

On January 29, 1993, the Maine Bureau of Insurance notified CMI that subscription to the IAEA Plan and

IAEA Trust does not satisfy CMI's obligation to provide workers' compensation benefits. See, Spugnardi Aff. ¶10 at Pet. App. 35a. The Bureau takes the position that the employer's obligation may be satisfied only by purchase of a workers' compensation and employee liability insurance policy from a carrier authorized to do business in Maine or by obtaining authorization to self-insure from the Bureau of Insurance. The Bureau rejected any notion that the IAEA Plan and IAEA Trust were preempted from State supervision by ERISA § 514(a), 29 U.S.C. § 1144 (West 1990, West Supp. 1993).

CMI commenced this case as an action seeking a declaratory judgment pursuant to 28 U.S.C. § 2201 (West 1990) and injunctive relief restraining the Bureau of Insurance from attempting to regulate or in any way interfering with the administration of the IAEA Plan and IAEA Trust on the grounds that the State's regulatory effort is preempted by ERISA. The Bureau of Insurance answered and objected to both CMI's proposed declaratory judgment and the grant of injunctive relief. The basic issue before the Court was joined. CMI then moved for a preliminary injunction.

Following a scheduling conference, the Magistrate Judge issued the following scheduling order which framed the controversy to be decided as a threshold issue as the first step in deciding the case:

> 3/29/92 [Plaintiff's motion to file memorandum in reply to the Bureau's objection to Plaintiff's motion for preliminary injunction is] [g]ranted in part as follows. During a telephone conference with counsel this date, it was agreed that the following threshold issue presented by this

> case should be decided first: *Assuming, arguendo, that the plan of the International Association of Entrepreneurs of America ("IAEA"), through which the plaintiff allegedly provides a variety of benefits to its employees is a so-called ERISA employees benefit plan, is Maine's workers' compensation law pre-empted by ERISA?* Plaintiff shall have to and including 4/12/93 within which to file a reply memorandum of not more than 15 pages addressing this issue only. The parties agree that no additional evidentiary materials need be presented on the issue. The threshold issue as framed shall be decided on the papers filed to date and the plaintiff's reply memorandum to be filed. If the question is answered in the affirmative, the court will confer with counsel concerning additional filings to be made to complete the evidentiary record and briefing on remaining issues relating to qualification of the IAEA plan for ERISA protection. /s/ David M. Cohen, USMJ." (Emphasis added.)

See, Pet. App. 31a-32a.

After consideration of the motion for preliminary injunction, the Magistrate Judge recommended that CMI's motion for preliminary injunction be denied and, acting *sua sponte*, recommended that the action be dismissed pursuant to Rule 12(c) of the F.R.Civ.P. The Magistrate Judge found in his Recommended Decision that the provisions of 39-A M.R.S.A. § 403 requiring the employer to obtain workers' compensation benefits by the purchase of insurance or by means of an authorized self-insurance plan, do not "relate to" an employee benefit plan within the meaning of 29 U.S.C. § 1144 (West 1990, West Supp.

1993) and are not preempted. The Court stated in relevant part as follows:

> ". . . . It is apparent from the language of [39-A M.R.S.A.] section 403 that its purpose is to guarantee the solvency of workers' compensation plans. The statute applies to all private employers, not just those who have adopted employee benefit plans covered by ERISA. It is not directed toward changing the rights or expectations of employee benefit plan participants. The plaintiff may comply with state law without altering its employee benefit plan although, admittedly, there may be duplication or increased cost. However, many state laws indirectly affect the cost of administering ERISA-covered plans but in doing so do not trigger ERISA preemption. See, *Aetna Life*, 869 F.2d at 146[1] (where state statute does not affect structure, administration or the type of benefits provided by the ERISA plan, mere fact statute has some economic impact on plan does not require it to be invalidated). As the Second Circuit has stated '[I]f ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, these plans will be permitted a charmed existence that never was contemplated by Congress.' *Rebaldo v. Cuomo*, 749 F.2d 133, 138-39 (2d Cir. 1984), cert. denied, 472 U.S. 1008 (1985)."

See, Pet. App. 28a-29a.

CMI asked for *de novo* review of the Recommended Decision on the grounds that *Aetna Life Insurance Co. v.*

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[1] The full citation is *Aetna Life Insurance Co. v. Borges*, 869 F.2d 142 (2d. Cir. 1989) cert. denied, 493 U.S. 811 (1989).

Borges, supra, and *Rebaldo v. Cuomo*, supra, had been abrogated by a more recent decision of the Second Circuit in *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 8 (2d Cir. 1992) in reliance upon *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139, 111 S. Ct. 478, 483, 112 L.Ed.2d 728 (1990) and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983). The U.S. District Court (Hornby, J.) construed *McCoy v. Massachusetts Institute of Technology*, 950 F.2d 13, 17 (1st Cir. 1991) cert. denied, 112 S.Ct. 1939 (1992) as affirming *Aetna Life Insurance Co v. Borges*, supra, and *Rebaldo v. Cuomo*, supra. The District Court affirmed and accepted the Recommended Decision of the Magistrate Judge. See.Pet. App. 19a-20a.

On appeal, the Court of Appeals for the First Circuit (Tortuella, J.) upheld and affirmed the Decision of the District Court. The First Circuit determined that a State does have authority to compel an employer to establish a separate plan for the provision of occupational disability benefits, and once established, those separate plans fall within the exception from preemption created by Congress at ERISA § 4(b)(3), 29 U.S.C. § 1003(b)(3) (West 1990, West Supp. 1993) for plans created solely to provide workers' compensation benefits. The Court relied primarily upon *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 106-109 and *District of Columbia v. Greater Washington Bd. of Trade*, ___ U.S. ___, 113 S.Ct. 580, 584-585, 121 L.Ed.2d 513 (1992). The provision of occupational disability benefits was found to be a matter of traditional State supervision and interest that Congress did not intend to preempt.

Even if there were no authority to require an employer to create a separately administered plan for the provision of occupational disability benefits, the First

Circuit found that the funding of such plans is a matter of critical State interest and at least equal in importance to the provision of the benefits in the first instance. Therefore, the First Circuit rationalized that *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 108 provides sufficient authority for the State to compel an employer to establish a separate plan "if the State is not satisfied that the ERISA comports with the requirements of its disability insurance law." *Id.*

It was determined on appeal that the State has a direct interest in assuring the payment of future benefits by regulating the funding of occupational disability benefits. Both the District Court and the Court of Appeals seem to assume that it is only the State that has this concern and has established a funding responsibility.

The Court of Appeals declined to address the question whether Maine's funding requirements have such an economic impact upon the IAEA Plan as to trigger preemption because the State's ability to require a separate plan was controlling. However, the Court did acknowledge that the question of the impact of increased costs is "far from settled". See, Pet. App. 15a, n. 5. Apparently by way of *dicta* the Court of Appeals did indicate that costs incurred as a result of State regulation must relate directly to the ERISA Plan and not simply add to employer's over-all cost of doing business. Therefore, 39-A M.R.S.A. § 403 does not "relate to" an ERISA plan and is not preempted. The Court cited *United Wire, Metal and Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179, 1181, 1193 (3rd Cir. 1993) cert den. 114 S.Ct. 651 (1993) as authority for the proposition that the incremental cost must directly effect the cost of providing benefits or administration before ERISA will preempt the

regulation. The cost to set-up and administer a second, separate plan was found, as a matter of law, to have too tenuous a relationship to the IAEA Plan as to be preempted.

The Decision of the District Court was affirmed.

REASONS FOR GRANTING THE WRIT

This case presents questions upon which the various Circuit Courts of Appeals are divided. The First and Ninth Circuits' clearly differ with the Second Circuit and, possibly other Circuits on the question whether taxation of employee benefits or funding requirements that increase a private employer's costs trigger preemption. *Travelers Insurance v. Cuomo*, 14 F.3rd 708 (2nd Cir. 1993) *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 1994 WL 278325 (2nd Cir. 1994); and *Travitz v. Northeast Dept. ILGWU Health & Welfare Fund*, 13 F.2d 704 (3rd Cir. 1993) (distinguishing *United Wire*) conflicts with *United Wire, Metal and Machine Health Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3rd Cir. 1993) and *Employee Staffing Services, Inc. v. Aubry*, 20 F.3rd 1038 (9th Cir. 1994) which were relied upon by the First Circuit as a controlling authority.

Also, the decision of the First Circuit in this case and the Ninth Circuit in *Employee Staffing Services, Inc. v. Aubry*, supra, appears to be in conflict with the decision of this Court in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983) by extending the power of the State to mandate minimum employee occupational disability benefits to regulation of the funding

and administrative aspects of employee welfare benefit plans.

The cost of workers' compensation benefits are a national concern. The cost of workers' compensation benefits in the United States is estimated to be $60 billion per year. See, J. Kilgour, *Workers Compensation Crisis; Developing Strategies to Address Costs, Benefits, Litigation and Fraud*, 2 ACA Journal (Winter 1993/1994). One analysis estimates that the cost to provide medical services for a work related injury is approximately double the cost to provide the same medical treatment for a non-work related injury. See, L. Baker and A. Krueger, *Twenty-Four Hour Coverage in Workers' Compensation Coverage*, Health Affairs, March 1993, pp. 271-281. As a result, employers are searching for a means to reduce such costs. These alternatives frequently include the provision of benefits through a fully integrated, self-insured plan providing a comprehensive benefit package. A recent survey indicates 75% of employers find state regulation of workers' compensation benefits to be unsatisfactory or difficult but manageable, and that 57% of employers now self-insure workers' compensation benefits. See, P. Plax, *Workers' Comp Their Way*, 7 Resource Executive (Nov. 1993).

The interest of other persons and entities in this case evidence the importance of the recent trend to provide occupational disability benefits through self-funded ERISA plans. Fourteen States, the U.S. Department of Labor, the AFL-CIO and Maine Employers Mutual Insurance Company all filed *amicus curiae* briefs in the First Circuit Court of Appeals in support of the Maine Bureau of Insurance.

Congress exercised its powers under the Commerce Clause of the United States Constitution, Art. 1, sec. 8, cl. 3, to authorize a federal benefit program. Congress specifically intended to promote uniform benefit programs exempt from crazy-quilt or patch-work regulation by the various states. The purpose was to make it possible for an employer to provide the most comprehensive package that it could afford and to avoid the cost and inefficiency of satisfying parochial regulation from each state in which the employer does business. It was recognized by Congress when it passed ERISA that each state has an interest in the well-being of its employee-citizens, but this local interest must yield to national interests.

President Clinton has proposed national health care legislation (Health Security Act, H.R. 3600/S. 1757). At least 6 other plans are before Congress. Only President Clinton has considered the role of state workers' compensation plans in the national health care plan. The Administration proposes only a special commission to consider the integration of State mandated workers' compensation benefits and national health care. There is no proposal in any plan that workers' compensation benefits be reserved to the States as a matter of traditional responsibility and interest. See, *BNA Occupational Safety and Health Daily*, April 23, 1993; April 25, 1994.

The Maine Workers' Compensation Act contradicts national policy stated in ERISA and the proposed health care legislation by requiring each private employer to submit his self-funded ERISA plan to funding regulations imposed by the Bureau of Insurance or to purchase a workers' compensation and liability policy from an insurer authorized to do business in Maine. It is not

possible to provide comprehensive health and disability benefits through an ERISA plan in Maine unless the employer agrees to State regulation of the plan administration. Interstate health benefit programs are subjected to patchwork regulation.

The First Circuit Court of Appeals found two bases for State regulation; namely workers' compensation benefits are a matter of traditional regulation as to both the benefits provided and the employer's ability to pay those benefits, and, secondly, such funding requirements have a tenuous or no relationship to the operation of the ERISA plan because the cost to provide workers' compensation benefits has no bearing, as a matter of law, on the cost to provide other benefits provided via an ERISA plan.

Both this Court and other Circuits have found that a State's regulation of the funding of an ERISA plan is preempted. Both this Court and other Circuits have found that State regulations resulting in an increase in the cost of operation of a multi-benefit, comprehensive ERISA plan "relate to" the plan and its preemption.

The First Circuit has attempted to find a judicial solution to a conflict between state and federal interests in the provision of employee benefits by reserving workers' compensation benefit plans to State regulation and excluding such plans from ERISA preemption. This conflict is a matter of legislative interest which should be resolved by Congress, and not by the courts. Congress acting pursuant to the Commerce Clause has exercised its ultimate authority by leaving the regulation of workers' compensation plan funding and administration to the states only if the plan is addressed solely to the meeting

of state obligations. See, ERISA § 4(b)(3), 29 U.S.C. § 1003(b)(3). The Maine Workers' Compensation Act attacks the basic purpose of ERISA by requiring separate plans or by controlling the funding of multi-benefits plans.

In sum, the diversity of opinion among the Circuits as to the authority of an employer to include workers' compensation benefits as a part of a multi-benefit ERISA plan needs clarification as private employers form alliances by means of employee leasing in an attempt to reduce benefit costs by amalgamating benefits into a single plan intended to provide a coordinated, single payor benefit package for employees on a national or regional basis.

ARGUMENT

I. ERISA's Overriding Purpose Is To Create a Uniform, National Program For The Provision Of Health, Disability And Retirement Benefits To America's Workers Exempt From State Regulation Relating To Such Benefit Plans.

It is well established that ERISA is a "comprehensive and reticulated statute". See, *Alessi v. Raybestos-Manhattan, Inc.* 451 U.S. 504, 510, 101 S.Ct. 1899, 68 L.Ed.2d 402 (1981), citing *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361, 100 S.Ct. 1723, 1726, 64 L.Ed.2d 354 (1980). The preemption provisions of ERISA were stated in the most broad terms to take exclusive federal jurisdiction over all benefit plans when the plans are formed solely to comply with state law. See, *District of Columbia v. Greater Washington Board of Trade*, ___ U.S. ___, 113 S.Ct. 580, 583, 121 L.Ed.2d 513 (1992); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77

L.Ed.2d 490 (1983). ERISA specifically includes "disability" benefit plans within the scope of national interest and preemption. See, ERISA § 3(1), 29 U.S.C. § 1002(1).

One of the principal congressional proponents of ERISA observed that ERISA's preemption clause was expanded from a relatively narrow concept to the most broad proportions. Senator Williams stated that ERISA, with final form, was "intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law". See, 120 Cong. Record 29, 333 (1974).

If an employer decides to adopt a multi-benefit ERISA plan, it becomes a matter of federal interest to facilitate the provision of benefits at the least cost. "The most efficient way to meet these [administrative] responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." See, *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9, 107 S.Ct. 2211, 2216, 96 L.Ed.2d 1 (1987) (one time payment of severance benefits not preempted). The federal goal is to reduce costs and burdens so that the employer is motivated to increase benefits.

It is undisputed that Maine's cost of workers' compensation and employee liability insurance is near the highest in the United States. See, *Report of Blue Ribbon Committee to Examine Alternatives to the Workers' Compensation System and to Make Recommendations Concerning the Replacement of the Present System*, August 1, 1992. The high cost is a result, at least in part, of an 8.5% surcharge imposed on Maine employers to fund a $250 million

deficit in the residual market, an assessment to create the Workers' Compensation Board Administrative Fund, and a 15% assessment for funding the capital of Maine Employers' Mutual Insurance Company, the fall-back insurance provider created by the Maine Legislature. See, Maine Bureau of Insurance Decision and Order, *In re: Workers' Compensation 1992 "Fresh Start" Proceeding*, Docket No. INS-92-116, November 18, 1992; Maine Bureau of Insurance Decision and Order, *In re: Workers' Compensation 1993 "Fresh Start" Proceeding*, Docket No. INS-93-16, May 28, 1993; Maine Bureau of Insurance Decision and Order, *Application of Maine Employers' Mutual Insurance Company to Obtain a Certificate of Insurance in Maine*, Docket No. INS-92-199, December 23, 1992; and 39-A M.R.S.A. § 154 (West Supp. 1993) (Board funding assessment).

The Bureau's funding requirements frustrate CMI's purpose to provide workers' compensation and disability benefits to its employees at a lesser cost by amalgamating the benefits into an ERISA plan providing a greater range of benefits. See Spugnardi Aff. ¶ 15 at Pet. App. 35a. CMI may also avoid administrative costs by utilizing the less expensive claims procedures available to an ERISA plan. See, 29 U.S.C. §§ 1132, 1133 (West 1990, West Supp. 1993). Compliance with the Bureau's order will threaten CMI's business. See, Spugnardi Aff. ¶ 15 at Pet. App. 35a.

The relevant language applicable in this or any other ERISA preemption case is as follows:

> "Except as provided in sub-section (b) of this section, the provisions of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee

> benefit plan described in section 1003(b) of this title and not exempt under section 1003(b) of this title. (Emphasis added.) ERISA 514(a), 29 U.S.C. § 1144(a)."

If the Maine Workers' Compensation Act "relates to" an employee benefit plan, any attempt by Maine to regulate the administration and funding of the plan is preempted.

II. The Maine Workers' Compensation Act Violates Federal Law And Policy Because It Specifically "Relates To" ERISA And it Purports To Regulate The Funding Of An ERISA Plan Or, In The Alternative, To Require A Separate Benefit Plan.

39-A M.R.S.A. §§ 401, 403 gives Maine employers two choices for the provision of workers' compensation benefits; i.e. the employer may purchase insurance or submit its self-funded benefit plan to the Maine Bureau of Insurance for review and approval as to all elements of workers' compensation benefits, including funding.

The Bureau's regulations are completely unique to Maine. No other state has the same qualification, administrative or funding provisions for self-insured plans providing occupational disability benefits. Three other states do have statutes purportedly to regulate self-insured employee benefit plans, but these laws vary from Maine. See, Conn. Gen. Stat. Ann. § 31-284(b) (West 1994), Neb. Rev. Stat. § 48-106 (West 1994); Mo. Ann. Stat. § 287.280 (Vernon 1994). California requires separate administration of workers' compensation benefit plans; Maine does not. See, Cal. Lab. § 700 (West 1994). Each employee benefit plan providing comprehensive benefits, including occupational death, disability benefits, to Maine

employees must submit to state regulation. This case suggests that, every state may impose its own set of regulations affecting workers' compensation; thus rendering it nearly impossible to provide coordinated benefits through a single plan on a multi-state basis. This theory is contrary to the principles established in *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 10-11, 107 S.Ct. 2211, 2216-2217, 96 L.Ed.2d 1 (1987). See also *Aloha Airlines, Inc. v. Auhe*, 12 F.3rd 1498, 1504-1505 (9th Cir. 1993) which found that a state may not require an employer to modify an existing plan or establish a new separate plan even in an area of traditional state regulation.

By specific reference in 39-A M.R.S.A. § 403(2) (West 1993), the Marine Workers' Compensation Act "relates to" ERISA plans, and Maine's regulatory effort exceeds the bounds established by prior decision of this Court. See, for example, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 108-110.

III. The Decision Of the First Circuit Court Of Appeals In This Case Seems To Contradict Previous Holdings Of This Court Preempting State Regulations Of ERISA Plan Administration While Permitting The State To Mandate Minimum Benefits.

At 22 F.3rd 6, the First Circuit found that funding of benefits is as important as the establishment of minimum benefits. The case law from this Court seems, by analogy, to create a hypothetical ERISA factory which produces benefits for employers. The State is allowed to direct the type of benefits to be produced for its citizens, but this Court has not permitted a State to go inside the factory to control the

manufacturing process. It is only when the State is dissatisfied with the benefits that it is allowed to create its own factory and manage the funding and administration processes. See *Shaw,* 463 U.S. at 107-108, 103 S.Ct. at 2905. Recognizing ERISA plans as administrative units, they should not be subject to "the administrative impracticality of permitting mutually exclusive pockets of federal and state jurisdictions within a plan . . . "

The language in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 108, refers only to "benefits". The Maine law focuses on payment of benefits. See, 39-A M.R.S.A. § 324 (West Supp. 1993). As *Shaw* found, it is the payment of the benefits to disabled workers that is of first interest. *Shaw* specifically allowed the benefits to be offered via a multi-benefit plan. The State may require that certain benefits be provided, but there is no case from this Court suggesting that the state may require separate or special funding of those benefits which are, in fact, being provided by the employer through its ERISA plan.

Petitioner argues that no decision of this Court has allowed a State to take regulatory action as authorized by the First Circuit in this case. The Ninth Circuit in *Employee Staffing Services, Inc v. Aubry,* 20 F.3rd at 1042 found that areas of traditional state responsibility which are reserved to that State and exempt from preemption are specifically identified in ERISA § 4, 29 U.S.C. § 1003. These exemptions in ERISA § 4, 29 U.S.C. § 1003 include plans created solely to meet state obligations and matters deemed to relate solely to insurance. See also, *FMC Corporation v. Holiday,* 498 U.S. 52, 60, 111 S.Ct. 403, 409, 112 L.Ed.2d 356 (1990) which similarly restricts the exemption from preemption. Therefore, preemptions are limited to specifically enumerated situations. See

also, *District of Columbia v. Greater Board of Washington Board of Trade*, ___ U.S. ___, 113 S.Ct. 580, 584, 121 L.Ed.2d 513 (1992) limiting exemption from preemption to those items described in ERISA § 4, 29 U.S.C. § 1003.

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. at 524, considered New Jersey's effort to ban pro-rated reduction of pension benefits payable to retired employees drawing workers' compensation benefits. The employer was allowed to decide how to pay and how much to pay through his ERISA plan without interference from New Jersey as long as the minimum workers' compensation benefits were paid.

The First and Ninth Circuits' extension of state regulations beyond those items designated in ERISA § 4, 29 U.S.C. § 1003(b) represents a new development in ERISA law that seems to contradict previous decisions of this Court.

IV. The Circuits Are Divided On The Question Whether A State Regulation Relating To An ERISA Plan May Avoid Preemption If It Relates Also To Workers' Compensation, A Matter Of Traditional State Interest.

The First Circuit Court of Appeals looked primarily to *Shaw v. Delta Air Lines, Inc.* 463 U.S. at 108, as authority that Maine can require an employer to meet both State mandated benefit and funding requirements relating to workers' compensation benefits.

> "In other words, while the State may not require an employer to alter its ERISA plan, it may force the employer to choose when providing disability benefits in a separately administered plan and including the State mandated benefits in its ERISA plan. If the State is not satisfied that the plan comports

> with the requirements or its disability insurance law, it may compel the employer to initiate a separate plan that does comply." *Shaw*, 463 U.S. at 108.

California's workers' compensation law differs from Maine law because California requires separate administration. The California employer may not provide such benefits through a comprehensive ERISA plan. See, Cal. Lab. § 700; *Employee Staffing Services, Inc. v. Aubry*, 20 F.3rd at 104; *Barker v. Pick N' Pull Auto Dismantlers, Inc.*, 819 F.Supp. 889, 892 (E.D. Cal. 1993). Maine specifically permits the use of broad based plans; therefore, there is a critical difference in the legal ramifications of the laws of the two States. Based upon *Employee Staffing*, the Ninth Circuit apparently will find preemption if the State provides a choice between providing benefits through a separate unit and an ERISA plan. Once the choice is available to the employer, the State law "relates to" an ERISA plan and is preempted. Presumably, Maine's law would be preempted in the Ninth Circuit. See also, *Aloha Airlines, Inc. v. Auhe*, 12 F.2d at 1505.

Other jurisdictions have focused on benefits as a matter of State interest and have left the funding and administration aspects to ERISA. Those jurisdictions have followed a troika of cases. See, i.e., *Shaw v. Delta Air Lines, Inc.*, supra; *Alessi v. Raybestos-Manhattan, Inc.*, supra; and *Ingersoll-Rand v. McLendon*, 498 U.S. 133, 11 S.Ct. 478, 118 L.Ed.2d 474 (1990).

The Fourth Circuit, in *PPG Industries Pension Plan A(CIO) v. Crews*, 902 F.2d 1148, 1150-1151 (4th Cir. 1990), found a West Virginia law to be preempted by ERISA because it required separate administration of workers' compensation benefits payable from a multi-benefit ERISA plan. The Fourth Circuit found that a principal purpose of ERISA was to allow an employer to combine funds in a separate

pool exempt from State regulation to pay benefits whether or not such benefits are mandated by the State. The Fourth Circuit would find both Maine and California laws relating to funding of benefits to frustrate the employer's effort to integrate benefits and, therefore, to be preempted by ERISA. The Fourth Circuit looked to *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 108 as the source of authority for its decision.

The fact that a State regulation of an ERISA plan falls in an area of traditional state interest was a controlling factor in this case and in *Employee Staffing*. In considering a non-workers' compensation issue, the Eighth Circuit found that the question of traditional state interest is not controlling and found that question to be a policy issue applicable only in borderline cases. See, *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1346, 1350 (8th Cir. 1991) cert. den. 112 S.Ct. 2305 (1992).

Therefore, there is disagreement among the Circuits whether any benefits are saved from preemption on that reason alone. Some Circuits find the State interest to be important only in borderline cases in which other factors are neutral. The economic impact of the Maine law upon the cost of benefits takes the analysis out of the borderline situation.

V. The Requirements Of The Maine Workers' Compensation Act Will Raise The Employers' Costs And Create Redundant Benefits. There Is Disagreement Among The Circuits Whether Such Costs Cause Preemption Of The State Regulation.

The District Court found that Petitioner's compliance with the Maine Workers' Compensation Act may result in

"duplication [of benefits] or increased cost". See, Recommended Decision at p. 8, Pet. App. 28a-29a. The District Court found further that the economic impact of State regulation does not result in preemption unless the regulation effects the structure, administration or type of benefits provided by the ERISA plan. The First Circuit Court of Appeals acknowledges that "the question of whether increased costs alone can trigger preemption is far from settled". See, 22 F.3rd at 7, n.5. (Pet. App. 15a)

The First Circuit seems to follow its decision in *McCoy v. Massachusetts Inst. of Technology*, 950 F.2d 13, 17 (1st Cir. 1991) in which it found that preemption is not triggered unless the increased cost from regulations applies specifically and uniquely to the ERISA plan as opposed to an overall increase in the employer's cost of doing business.

Similarly, findings of the Ninth Circuit in *Employee Staffing Services, Inc. v. Aubry*, 20 F.3rd at 1042 seem to be in accord with the First Circuit. The Ninth Circuit stated "[w]e venture no opinion on the economic desirability of such a scheme [required compensation insurance in a separate plan], or of enabling forms to avoid burdensome state workers' compensation requirements, or of the practical sense of a state requiring firms to duplicate workers' compensation benefits already provided in ERISA plans. We decide only that the State of California has power, not how it should exercise it. The practical policy decision about how to exercise that power, balancing the breadth and security of benefits against the loss of jobs as payroll costs increase, must be left to the democratic process of California."

Plainly and simply, the judicial policy decisions of the First and Ninth Circuits contradict the base policy of ERISA.

It is the principal purpose of ERISA to streamline the provision of benefits and to reduce costs in order to increase the benefits that the employer can afford to provide. See, *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. At 10-11, 107 S.Ct. at 2216-2217.

The Second Circuit has taken the position that regulation creating redundant benefits and the increased costs to provide benefits are the stuff that Congress intended to preempt. See, *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 (2nd Cir. 1992) in which the Second Circuit stated that an indirect effect on the ERISA plan triggered preemption and further found that a state law of general application effecting the amount or costs of benefits was preempted.

Also in the Second Circuit, New York imposed a surcharge on services provided to HMOs and insurers in order to force employers to switch benefits programs to Blue Cross/Shield. The Second Circuit found that *Smith v. Dunham-Bush, Inc.*, 955 F.2d at 9 and *Ingersoll-Rand, Co. v. McLendon*, 498 U.S at 139, 11 S.Ct. at 483, dictated that such surcharges are preempted by ERISA because they were intended to and did have a substantial effect, albeit indirect, on the New York ERISA plans. See *Travelers Insurance Co. v. Cuomo*, 14 F.3rd at 719-720 (2nd Cir. 1993). The Second Circuit would find preempted those provisions in the Maine Workers' Compensation Act that cause redundant benefits and increased benefit costs. See also, *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 1994 WL 278325 (2nd. Cir. 1994).

It is arguable that the Maine Workers' Compensation Act would be preempted in the Third Circuit. In *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Mem.*

Hospital, 995 F.2d at 1194-1195, the Third Circuit found no *nexus* to an ERISA plan in a unique way as the result of generally applicable legislation attempting to control hospital costs. Maine, however, specifically requires employee benefit plans to buy insurance or subject the fund to State regulation. It has been found by the District Court in this case that the Maine law does have a resulting increase in costs. Therefore, the nexus is established to effect an ERISA plan differently than employers who do not self-insure. In *Travitz v. Northeast Dept. ILGWU Health & Welfare Fund*, 13 F.2d 704, 709-710 n. 5 (3rd Cir. 1993) the Court distinguishes *United Wire* and found that a Pennsylvania statue making ERISA plans primarily liable for injuries suffered in auto accidents increased the ERISA plan's potential for liability and increasing costs could lead to reduced benefits and was preempted. The developing law in the Third Circuit indicates that the effect of the Maine regulation would cause preemption.

The Fifth Circuit considered indirect effect on ERISA plans in *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir. 1991) cert. den., 112 S.Ct. 585 (1991). Texas attempted to impose a tax upon all persons providing services to employee benefit plans. Obviously *E-Systems* does present a situation in which a state attempted to tax ERISA plans in a unique manner. Maine requires that ERISA plans must purchase insurance or receive authorization to self-insure. In the first instance, the ERISA plan is subject to surcharges and assessments to fund shortcomings in the Maine workers' compensation system. In the second instance, the ERISA plan must pay into the self-insurance guarantee fund. Again, it is noteworthy that the Maine statute specifically includes employee benefit plans within its scope. It is arguable that

the Fifth Circuit would preempt the Maine funding requirements on the basis that the legislation increases costs of operation and benefit costs in a direct, material way. Recent Decisions in other Circuits also tend to confirm that regulations increasing costs are preempted even if the regulation is in an area of traditional state interest. See, *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d at 1348; In re *Michigan Carpenters Council Health & Welfare Fund*, 933 F.2d 376, 382-383 (6th Cir. 1990) cert. den. 112 S.Ct. 585 (1991); *National Elevator Industries, Inc. v. Calhoon*, 957 F.2d 1555, 1561 (10th Cir. 1992) cert. den. 113 S.Ct. 406 (1992).

The law relating to the preemption of regulations affecting an economic impact upon ERISA plans is unclear and unsettled. The requirement that an ERISA plan subject itself to redundant funding and benefits at an incremental costs would, in all likelihood, be preempted in the Second, Third and Fifth circuits; and perhaps in the Ninth Circuit, but not in the First Circuit.

CONCLUSION

For the reasons set forth above, this Petition for Writ of *Certiorari* should be granted.

Respectfully submitted,

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COMBINED MANAGEMENT, INC., Plaintiff, Appellant,

v.

SUPERINTENDENT OF THE BUREAU OF INSURANCE OF THE STATE OF MAINE, Defendant, Appellee.

No. 93-1874

United States Court of Appeals,
First Circuit.

Heard Jan. 6, 1994.

Decided April 22, 1994.

Employer brought action to enjoin Maine's Superintendent of the Bureau of Insurance from enforcing statutory requirement that separate workers' compensation plan be maintained. The United States District Court for the District of Maine, D. Brock Hornby, J., dismissed, and empioyer appealed. The Court of Appeals, Torruella, Circuit Judge, held that Maine law requiring separately administered workers' compensation plan was not preempted by Employee Retirement Income Security Act (ERISA).

Affirmed.

Richard G. Moon with whom Ralph A. Dyer, Portland, ME, was on brief for appellant.

James M. Bowie, Asst. Atty. Gen., Dept. of the Atty. Gen., with whom Michael E. Carpenter, Atty. Gen., Linda M. Pistner, Director, Regulatory Agency Unit, Dept. of the Atty. Gen., and Thomas D. Warren, Director, Litigation Unit, Dept. of the Atty. Gen., Augusta, ME, were on brief for appellee.

Robert Abrams, Atty. Gen., of the State of New York, Jerry Boone, Sol. Gen., Jane Lauer Barker, Asst. Atty. Gen. in Charge of Labor Bureau, and Jennifer S. Brand, Asst. Atty. Gen., New York City, on brief for State of NY, et al., amici curiae.

John M. Rea, Chief Counsel, Vanessa L. Holton, Sr. Counsel, James D. Fisher, Staff Counsel, Gary J. O'Mara, Staff Counsel, Dept. of Industrial Relations, and Lloyd Aubry, Jr., Director, Dept. of Industrial Relations, State of CA, San Francisco, CA, on brief for State of CA, amicus curiae.

Marsha S. Berzon, Michael Rubin, Indira Talwani, Altshuler, Berzon, Nussbaum, Berzon & Rubin on brief, San Francisco, CA, for the American Federation of Labor and Congress of Industrial Organizations and the International Ladies' Garment Workers' Union, AFL-CIO, amici curiae.

Thomas S. Williamson, Jr., Sol. Of Labor, Marc I. Machiz, Associate Sol., Plan Benefits Sec. Div., Karen L. Handorf, Counsel for Special Litigation, Plan Benefits Sec. Div., and Elizabeth A. Goodman, Trial Atty., Plan Benefits Sec. Div., U.S. Dept. of Labor, on brief, Washington, DC, for the Secretary of Labor, amicus curiae.

Allan M. Muir and Pierce, Atwood, Scribner, Allen, Smith & Lancaster, Portland, ME, on brief for Maine Employers' Mut. Ins. Co., amicus curiae.

Michael M. Sykes, General Counsel, Oklahoma Dept. of Labor, and Kayla A. Bower, Attorney, Oklahoma Dept.

of Labor, on brief, Oklahoma City, OK, for State of Oklahoma ex rel. Dave Renfro, Commissioner of Labor, Oklahoma Dept. of Labor, amicus curiae.

Before TORRUELLA, ALDRICH and CYR, Circuit Judges.

TORRUELLA, Circuit Judge.

Plaintiff-Appellant, Combined Management, Inc. ("CMI"), brought an action to enjoin Brian K. Atchinson, in his representative capacity as Superintendent of the Bureau of Insurance for the State of Maine (the "Superintendent"), from enforcing certain provisions of Maine's workers' compensation statute. 39-A M.R.S.A. § 101 *et seq.* CMI claimed that because CMI provides workers' compensation benefits through a welfare benefit plan that is covered by the Employee Retirement Income Security Act ("ERISA"), the Superintendent's efforts to apply the workers' compensation law to CMI are preempted by ERISA § 514(a) of ERISA, 29 U.S.C. § 1144(a). The district court dismissed CMI's complaint, finding that ERISA did not preempt Maine law. We affirm.

I. BACKGROUND

CMI is an employee leasing company that leases the services of its workers' [sic] to a variety of businesses on a long-term basis. CMI provides employee benefits including occupational injury and disability benefits, to the leased employees through a subscription to the international Association of Entrepreneurs of America Welfare Benefit Plan (the "IAEA Plan"). The workers' compensation portion of the IAEA Plan is not separately insured or administered.

Maine state law, 32 M.R.S.A. § 14055(1)(B), mandates that employee leasing companies or their client businesses must arrange for the payment of workers' compensation benefits in accordance with the requirements of the Maine Workers' Compensation Act, 39-A M.R.S.A. § 101 *et seq.* The Workers' Compensation Act requires that all employers provide workers' compensation either through an insurance carrier authorized by the state or through a self-insurance plan that meets the state's qualifications. 39-A M.R.S.A. § 403.2.[1] Maine requires authorized insurance carriers and self-insurers to provide

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[1] 39-A M.R.S.A. § 403 provides in part:

An employer subject to [the Workers' Compensation] Act shall secure compensation and other benefits to the employer's employees in one or more of the ways described in this section. . . .

1. INSURING UNDER WORKERS' COMPENSATION INSURANCE POLICY. The employer may comply with this section by insuring and keeping insured the payment of such compensation and other benefits under a workers' compensation insurance policy. . . .

2. PILOT PROJECTS. [The employer may participate in an authorized pilot project.] . . .

3. PROOF OF SOLVENCY AND FINANCIAL ABILITY TO PAY; TRUST. The employer may comply with this section by furnishing satisfactory proof to the Superintendent of Insurance of solvency and financial ability to pay the compensation and benefits, and depositing cash, satisfactory securities, irrevocable standby letters of credit issued by a qualified financial institution or a surety bond with the board, in such sum as the superintendent may determine. . . .

4. GROUP SELF-INSURERS; APPLICATION. Except for the provision relating to individual public employer self-insurers, subsection 3 is equally applicable in all respects to group self-insurers.

evidence of their financial solvency and meet certain funding requirements. *See, e.g.*, 24-A M.R.S.A. §§ 221-A, 410, 4431-4452; 39-A M.R.S.A. §§ 403, 404.

On January 29, 1993, the Maine Bureau of Insurance sent a letter to CMI stating that CMI's subscription to the IAEA Plan did not satisfy its obligation under state law to provide workers' compensation benefits through one of the methods authorized by 39-A M.R.S.A. § 403. The letter did not "constitute a formal order or action of the Superintendent" but it did warn that failure of CMI to comply with the law could prompt some action in the future.

One month later, CMI filed suit to enjoin the Superintendent from requiring CMI to obtain separate workers' compensation insurance or to establish a qualified program of self-insurance pursuant to 39-A M.R.S.A. § 403. CMI also sought a declaratory judgment stating that any enforcement of 39-A M.R.S.A. § 403 against CMI is preempted by ERISA.

In response to CMI's request for a preliminary injunction, the magistrate judge suggested that he first address the issue of whether ERISA preempted Maine's workers' compensation laws. Although CMI would have to establish that its benefit plan, the IAEA Plan, was an ERISA covered plan under 29 U.S.C. §§ 1002(3) and 1002(37)(A) before it could invoke the protections of ERISA's preemption provision, the magistrate noted that determining the status of the IAEA Plan would involve a fact intensive inquiry requiring additional discovery. Instead, with the agreement of the parties, the magistrate ordered that the preemption issue be addressed first on

the understanding that if he found ERISA did not preempt Maine law, he would then dismiss the case. Thus, for purposes of this threshold question only, the IAEA Plan is assumed to be a valid ERISA benefit plan.

On June 15, 1993, the magistrate recommended a denial of the requested preliminary injunction and a dismissal of the case on the grounds that ERISA did not preempt Maine's workers' compensation law. The magistrate found that the workers' compensation law did not "relate to" the IAEA Plan offered by CMI because the law is a matter of general application affecting all private employers, whether or not they have adopted ERISA plans, and because the law does not affect the structure, administration, or type of benefits provided by any ERISA plan. On August 2, 1993, the district court affirmed and adopted the magistrate's recommended decision. CMI now appeals this decision.

II. ERISA PREEMPTION

ERISA preempts state laws that "relate to" an ERISA covered welfare benefit plan. ERISA § 514(a), 29 U.S.C. § 1144(a).[2] A state law "relates to" an ERISA covered plan " 'if it has a connection with or reference to such a plan.' " *District of Columbia v. Greater Washington Bd. of Trade*, ___ U.S. ___, ___, 113 S.Ct. 580, 583, 121 L.Ed.2d 513 (1992)

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[2] Section 514(a) provides that the provisions of ERISA:

> shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a).

(quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490 (1983)); *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139, 111 S.Ct. 478, 483, 112 L.Ed.2d 474 (1990). A state law may "relate to" a benefit plan "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Greater Washington Bd. of Trade*, ___ U.S. at ___, 113 S.Ct. at 583 (quoting *Ingersoll-Rand*, 498 U.S. at 139, 111 S.Ct. at 483). However, preemption will not occur where the state law has only a "tenuous, remote, or peripheral" connection with covered plans, "as is the case with many laws of general applicability." *Id.* ___ U.S. at ___ n. 1, 113 S.Ct. at 583 n. 1 (citing *Shaw*, 463 U.S. at 100 n. 21, 103 S.Ct. at 2901 n. 21); *see also Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830-38, 108 S.Ct. 2182, 2185-90, 100 L.Ed.2d 836, 1988).

State laws that do not "relate to" an ERISA covered plan but instead "relate to" a benefit plan established solely to comply with state workers' compensation laws are not preempted by ERISA. Section 514(a); ERISA § 4(b)(3), 29 U.S.C. § 1003(b)(3).[3] As Maine's workers' compensation law falls within this special exemption, we affirm the district court's determination that ERISA does not preempt any efforts by the Superintendent to require CMI to provide workers' compensation benefits through

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[3] Section 4(b)(3) provides that ERISA shall not apply to any employee benefit plan if:

> such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws.

29 U.S.C. § 1003(b)(3).

an authorized insurance provider or qualified self-insurance. *See Employee Staffing Servs., Inc. v. Aubry,* 20 F.3d 1038 (9th Cir.1994) (holding that California's workers' compensation law, which is quite similar to Maine's, is not preempted by ERISA).

A. *The Worker's Compensation Exemption*

Congress explicitly exempted state workers' compensation schemes from ERISA's purview, *see,* H.R.Rep. No. 93-1280, 93d Cong., 2d Sess. 383 (1974), *reprinted in* 1974 U.S.Code Cong. & Admin. News 4639, 5038, 5162, leaving intact the states' traditional regulation and oversight of this specialized system of insurance. *See also* 28 U.S.C. § 1445(c) (forbidding removal of workers' compensation benefits claims to federal court). In the statute, § 4(b)(3) excludes benefit plans created solely to comply with state workers' compensation statutes from coverage under ERISA, and § 514(a) excludes from preemption state laws that relate to those plans described in § 4(b). 29 U.S.C. §§ 1003(b) and 1144(a). Some state workers' compensation laws might "relate to" ERISA covered benefit plans, instead of, or in addition to, plans exempt under § 4(b)(3), and thus fall under the broad sweep of ERISA's preemption clause. *Greater Washington Bd. of Trade,* ___ U.S. at ___, 113 S.Ct. at 584-85. Laws which relate *only* to welfare benefit plans exempt from ERISA's coverage, however, fit safely under the umbrella of § 4(b)'s exemption. *Id.*

In *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 106-09, 103 S.Ct. 2890, 2905-06, 77 L.Ed.2d 490 (1983), the Supreme Court held in part that a New York law mandating the provision of certain disability benefits to employees was

exempt from preemption under ERISA pursuant to § 4(b)(3), even though employers could provide the required benefits through their ERISA covered plans. Because disability benefit laws are exempted from ERISA's coverage by the same provision exempting workers' compensation laws, § 4(b)(3), 29 U.S.C. § 1003(b)(3), the *Shaw* decision applies directly to this case. The Supreme Court found in *Shaw* that:

> A State may require an employer to maintain a disability plan complying with state law as a separate administrative unit. Such a plan would be exempt under § 4(b)(3). . . . [W]hile the State may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan. If the State is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply.

Id. at 108, 103 S.Ct. at 2905-06. *See also Greater Washington Bd. of Trade*, ___ U.S. at ___, 113 S.Ct. at 584-85 (reaffirming the holding in *Shaw*).

The Supreme Court also noted that although the exemption in § 4(b)(3) applies only to separately administered disability plans maintained solely to comply with state law, and does not include ERISA covered benefit plans that provide a combination of exempt and non-exempt benefits, employers are not:

> completely free to circumvent the Disability Benefits Law by adopting plans that combine disability benefits inferior to those required by

> that law with other types of benefits. Congress surely did not intend, at the same time it preserved the role of state disability laws, to make enforcement of those laws impossible.

Shaw, 463 U.S. at 108, 103 S.Ct. at 2905.

Maine's workers' compensation law falls squarely within the dictates of *Shaw*. 39-A M.R.S.A. § 403 mandates that employers provide workers' compensation by purchasing approved insurance or by establishing an approved self-insurance plan. This is precisely what the Supreme Court contemplated when it found that states "may require an employer to maintain a [§ 4(b)(3) exempt] plan as a separate administrative unit." *Id.*; *accord Greater Washington Bd. of Trade*, ___ U.S. at ___, 113 S.Ct. at 584-85. In the present case, the Superintendent expressed an opinion that CMI's subscription to the IAEA Plan does not satisfy the requirements of Maine's law. Further efforts to ensure CMI's compliance with the law would clearly constitute an act to "compel the employer to maintain a separate plan that does comply" with the workers' compensation law, an act which is explicitly approved of by *Shaw*. *Shaw*, 463 U.S. at 108, 103 S.Ct. at 2906.

Even though CMI provides workers' compensation benefits through the IAEA Plan, which we assumed is an ERISA covered plan, Maine's law does not require, and the Superintendent does not request, that CMI alter the IAEA Plan in any way or provide or not provide certain benefits through the IAEA Plan. In fact, the Maine law imposes no limitations or requirements, regulatory or otherwise, on the IAEA Plan or on any ERISA covered plan. Consequently, it does not "relate to" an ERISA plan

such that preemption is triggered. In such a situation, CMI cannot don the mantle of ERISA preemption simply by including workers' compensation benefits in its welfare benefit plan and thereby escape the requirements of Maine's law. *See Shaw,* 463 U.S. at 108, 103 S.Ct. at 2905-06; *Foust v. City Ins. Co.,* 704 F.Supp. 752, 754 (W.D.Tex.1989).

CMI misinterprets *Shaw* to hold that states can only require employers to provide a specified level or package of workers' compensation benefits and cannot otherwise interfere with plan administration through provisions like the funding and solvency requirements established in 39-A M.R.S.A. § 403. CMI would thus limit the ERISA exemption under § 4(b)(3) to laws mandating benefit outputs instead of laws establishing separate benefit plans. As a corollary to this claim, CMI contends that *Shaw* requires states to give employers a choice of providing the specified benefits in its own ERISA plan or in a state mandated benefits plan. CMI maintains that because ERISA allows welfare benefit plans to provide workers' compensation benefits, refusing to give CMI the option of providing such benefits through the IAEA Plan would effectively bar what ERISA permits. *See Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504, 524, 101 S.Ct. 1895, 1906-07, 68 L.Ed.2d 402 (1981) (finding state law that barred one method of calculating benefits permitted by ERISA to be preempted).

CMI cites several cases for the proposition that states may not force employers *to separate* workers' compensation benefits from their fully integrated ERISA plans. *Id.* at 521-26, 101 S.Ct. at 1905-08; *PPG Industries Pension Plan A v. Crews,* 902 F.2d 1148, 1150-51 (4th Cir.1990). CMI

extends this proposition to argue that states are also prohibited from forcing employers *to set up* separate workers' compensation plans.

Although ERISA preempts state laws that prohibit an ERISA covered plan from providing certain benefits or from calculating benefits in a certain way (including laws that would force a plan *to separate* out a portion of its existing coverage), we find no support in *Shaw*, or any other case, for CMI's proposition that ERISA preempts state laws that force employers *to adopt* a separately administered workers' compensation benefits plan. On the contrary, § 4(b)(3) and *Shaw* itself expressly permit states to do just that. *Shaw*, 463 U.S. at 108, 103 S.Ct. at 2905-06. *Shaw* does not require states to give employers the option of complying with state law by providing workers' compensation benefits in their ERISA covered plans. Instead, *Shaw* merely states that the existence of such an option does not automatically result in preemption, *id.* at 108, 103 S.Ct. at 2905-06; it certainly does not suggest the converse proposition, that an option is required for the § 4(b)(3) exemption to apply. *See Barker v. Pick N Pull Auto Dismantlers, Inc.*, 819 F.Supp. 889, 891-96 (E.D.Cal. 1993) (rejecting the identical argument that *Shaw* requires states to offer employers the option of providing workers' compensation through their ERISA plans).[4]

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[4] We note that this case differs from our recent decision in *Simas v. Quaker Fabric Corp.*, 6 F.3d 849 (1st Cir.1993), where we held that states cannot mandate the establishment of an ERISA covered plan. *Id.* That holding does not apply to state workers' compensation laws such as Maine's which mandate the establishment of exempt, non-ERISA covered plans.

Likewise, *Shaw* does not limit the exemption under § 4(b)(3) to state laws mandating a specific level or package of benefits as opposed to laws mandating solvency and funding requirements. There is no basis for this distinction in § 4(b)(3) or in *Shaw*. Additionally, the language of those two authorities indicates that the case for exemption of solvency requirements is even stronger than the case for exemption of benefit requirements. *See* § 4(b)(3), 29 U.S.C. § 1003(b)(3) (stating that the provisions of ERISA shall not apply to any employee benefit plan if "such *plan* is maintained solely for the purpose of complying with applicable workmen's compensation *laws*") (emphasis added); *Shaw*, 463 U.S. at 108, 103 S.Ct. at 2905 (stating that states can require employers to comply with the "requirements" of its law by setting up "a separate administrative unit"); *see also Barker*, 819 F.Supp. at 895 (finding that "*Shaw* does not address 'benefits' but speaks only of 'requirements,' " and that a state's concern about the solvency of a workers' compensation plan is "of equal stature as any concern as to the level of benefits."). If anything, state laws mandating specific benefits from an ERISA covered plan are more likely to "relate to" that ERISA plan than laws which merely require the creation of an ERISA-exempt plan and which make no demands on the ERISA covered plan itself. Thus, the instant case presents an even clearer application of § 4(b)(3)'s exemption than does *Shaw*.

Maine's law does not bar what ERISA permits. CMI remains free to provide the existing workers' compensation benefits to its employees and to integrate such benefits with the rest of its ERISA plan benefits. We are not presented in this case with a state workers' compensation

law that prohibits ERISA covered plans from calculating pension benefits in a certain way, *see Alessi*, 451 U.S. at 521-26, 101 S.Ct. at 1905-08 (finding that ERISA preempted New Jersey law that prohibited ERISA plans from offsetting pension benefits by amounts awarded for workers' compensation); *PPG Industries*, 902 F.2d at 1150-51 (finding preemption of West Virginia law that prohibited an employer from deducting the amount of pension benefits previously paid to a retiree from the retiree's subsequent workers' compensation award), or a law that specifically refers to ERISA covered benefit plans in order to determine workers' compensation benefits, *see Greater Washington Bd. of Trade*, ___ U.S. at ___, 113 S.Ct. at 583-85 (holding that ERISA preempted District of Columbia law requiring that employers who provide health insurance coverage for their employees under an ERISA plan must provide equivalent health insurance coverage for injured employees eligible for workers' compensation). These cases cited by CMI in support of its misguided interpretation of *Shaw* found preemption for reasons that do not apply to this case. We therefore find that a state law that requires employers to operate a separately administered workers' compensation benefit plan is not preempted by ERISA.

B. *Does Maine's Law Nevertheless "Relate To" the IAEA Plan?*

CMI further argues that Maine's workers' compensation law relates to an ERISA plan, and thus is preempted, because the law affects the cost of providing ERISA benefits to its employees. Specifically, CMI alleges that if it is

forced to adopt a separate workers' compensation plan, the burdens of duplicate administration and the higher cost of separate workers' compensation benefits provided outside of the integrated IAEA Plan will have a significant economic impact on CMI and render CMI unable to afford the existing level of benefits now offered through the IAEA Plan. According to CMI, a state law that creates a significant economic impact on an ERISA plan, without more, sufficiently "relates to" the plan and is therefore preempted. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.), *cert. denied*, ___ U.S. ___, 112 S.Ct. 585, 116 L.Ed.2d 610 (1991); *Travelers Ins. Co. v. Cuomo*, 813 F.Supp. 996, 1002-06 (S.D.N.Y.1993).[5]

To begin with, we decline to address whether a significant economic impact on an ERISA covered plan may be sufficient by itself to trigger preemption because CMI's argument fails regardless of how that issue is resolved. The argument fails for two reasons. First, CMI's claim is at odds with *Shaw* and *Greater Washington Bd. of Trade*, in which the Supreme Court explicitly contemplated state laws requiring the separate administration of

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[5] As CMI points out, *Travelers* cites *FMC Corp. v. Holliday*, 498 U.S. 52, 58-60, 111 S.Ct. 403, 407-09, 112 L.Ed.2d 356 (1990), for the proposition that state laws that increase plan costs are preempted. *Travelers*, 813 F.Supp. at 1006. *FMC Corp. v. Holliday* makes no mention of state laws that merely impose additional costs. Instead, the Supreme Court found that state laws interfering with an ERISA plan's calculation of benefits, in that case through a state antisubrogation law, was preempted. *FMC Corp.*, 498 U.S. at 58-60, 111 S.Ct. at 407-09. Although we need not decide the issue in this case, the question of whether increased costs alone can trigger preemption is far from settled.

workers' compensation plans without "relating to" existing ERISA plans. *Greater Washington Bd. of Trade*, ___ U.S. at ___, 113 S.Ct. at 584-85; *Shaw*, 463 U.S. at 108, 103 S.Ct. at 2905-06.

Second, Maine's law, while having an economic impact on CMI, does not have an economic impact on the IAEA Plan itself. Clearly, any law that increases a company's cost of doing business can be said to affect that business's ability to provide benefits under its welfare benefit plan. This is not the same, however, as imposing burdens on the welfare benefit plan itself. The increased cost or administrative burdens imposed by the state law must have some connection to the covered ERISA plan before the preemption analysis can come into play. *See United Wire, Metal and Machine Health & Welfare Fund v. Morristown Mem. Hosp.*, 995 F.2d 1179, 1193 (3d Cir.1993) ("Where there is no direct nexus between a state statute and ERISA plans, no effect on the manner of such plans' conducting business or their ability to operate in interstate commerce, statutes have been upheld despite the fact that they may have the indirect ultimate effect of increasing plan costs.").

In requiring CMI to provide separate coverage for workers' compensation, Maine does not increase the operational expenses or input costs of the IAEA Plan,[6]

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[6] In contrast, two cases that defendant relies upon, *E-Systems* and *Travelers*, involve laws that increase the costs of plan operation. *See E-Systems*, 929 F.2d at 1103 (finding that because the state tax in that case was collected from an ERISA covered plan, the "cost of the plan must therefore increase"); *Travelers*, 813 F.Supp. at 1003 (finding "little doubt that the Surcharges at

nor does it impose any additional administrative burdens, benefit requirements, or other obligations on the IAEA Plan. Maine's law may increase CMI's cost of doing business, but it does not affect the IAEA Plan's cost of providing benefits or costs of administration. Should CMI choose voluntarily to change its coverage under the IAEA Plan in response to Maine's law, we consider such a decision to constitute, at most, an effect of the law that is too "tenuous" and "remote" to warrant preemption. *See Employee Staffing Servs., Inc. v. Aubry*, No. C-92-4096, 1993 WL 83310 (N.D.Cal.1993), *aff'd*, 20 F.3d 1038 (9th Cir.1994); *cf. Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831-32, 108 S.Ct. 2182, 2986-87, 100 L.Ed.2d 836 (1988) (finding generally applicable state garnishment law did not "relate to" ERISA covered plans even though the law might burden the administration of such plans); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145-46 (2d Cir.), *cert. denied*, 493 U.S. 811, 110 S.Ct. 57, 107 L.Ed.2d 25 (1989) (finding state escheat law did not "relate to" ERISA plans and noting that ERISA does not preempt many laws that have a minimal, indirect impact on plan administration); *Martori Bros. Distributors v. James-Massengale*, 781 F.2d 1349, 1358-59 (9th Cir.), *cert. denied*, 479 U.S. 1018, 107 S.Ct. 670, 93 L.Ed.2d 722 (1986) (finding state unfair labor practices statute that required employers to pay damages based in part on fringe benefits employees would have received if employers had bargained in good faith did not "relate to" an ERISA

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issue will have a significant effect on the commercial insurers and HMOs which do or could provide coverage for ERISA plans and thus lead, at least indirectly, to an increase in plan costs") (footnote omitted).

plan). We find therefore that Maine's law does not "relate to" an ERISA covered plan and is not thereby preempted.

Accordingly, the order of the district court is affirmed.

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

COMBINED MANAGEMENT, INC., PLAINTIFF	)	CIVIL NO. 93-39-P-H
v.	)	(FILED AUG. 2, 1993)
BRIAN K. ATCHINSON, SUPERINTENDENT, BUREAU OF INSURANCE, STATE OF MAINE, DEFENDANT	)	

ORDER AFFIRMING RECOMMENDED DECISION OF THE MAGISTRATE JUDGE

The United States Magistrate Judge filed with the court on June 15, 1993, with copies to counsel, his Recommended Decision on Motion for Preliminary Injunction. The plaintiff filed its objection to the Magistrate Judge's Recommended Decision on June 25, 1993. I have reviewed and considered the Magistrate Judge's Recommended Decision, together with the entire record; I have made a *de novo* determination of all matters adjudicated by the Magistrate Judge's Recommended Decision; and I concur with the recommendations of the United States Magistrate Judge for the reasons set forth in his Recommended Decision, and determine that no further proceeding is necessary.

I am satisfied that the portions of *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989), and *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984),

cert. denied, 472 U.S. 1008 (1985), relied upon by the United States Magistrate Judge remain good law. *See, e.g., McCoy v. Massachusetts Inst. of Technology*, 950 F.2d 13, 17 (1st Cir. 1991) (referring to Rebaldo), *cert. denied*, 112 S. Ct. 1939 (1992).

It is therefore ORDERED that the plaintiff's motion for preliminary injunction is DENIED and the action is DISMISSED.

SO ORDERED.

Dated at Portland, Maine this 2nd day of August, 1993.

/s/ D. Brock Hornby
D. Brock Hornby
United States
District Judge

UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

COMBINED MANAGEMENT, INC.,	)	
Plaintiff	)	*Civil No. 93-39-P-H*
v.	)	**(Filed June 15, 1993)**
BRIAN K. ATCHINSON, SUPERINTENDENT, BUREAU OF INSURANCE, STATE OF MAINE,	)	
Defendant	)	

RECOMMENDED DECISION ON MOTION FOR PRELIMINARY INJUNCTION

This matter is before the court on the plaintiff's motion for a preliminary injunction to prohibit the defendant, Superintendent of the Maine Bureau of Insurance, from enforcing its compliance with Maine's workers' compensation law. The plaintiff claims that because it provides occupational disability insurance benefits through its subscription to a multi-employer welfare benefit plan covered by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461, the Superintendent's authority to regulate its workers' compensation plan is preempted by ERISA.

BACKGROUND

The plaintiff, Combined Management, Inc. ("CMI"), is an employee leasing company located and duly

registered in Maine. It pays the wages of the employees it leases to client companies, withholds and remits applicable federal and state taxes and provides its leased employees with a variety of employee welfare benefits, including medical and surgical coverage, dental coverage, vision care coverage and accidental death and dismemberment coverage. These benefits are provided through a subscription to the International Association of Entrepreneurs of America Welfare Benefit Plan ("Plan"), which the plaintiff assets is a multi-employer welfare benefit plan as defined by 29 U.S.C. § 1002(3) and (37)(A). The Plan is established and maintained by the International Association of Entrepreneurs of America Trust ("Trust") for the benefit of the employees and dependents of members of the International Association of Entrepreneurs of America ("IAEA"). Among the benefits provided to the plaintiff's employees through the Plan are occupational injury and illness benefits like those mandated by the Maine workers' compensation laws currently in effect. CMI pays the entire premium for work-related injury and illness coverage. These benefits are neither separately insured nor separately administered.

In January 1993 the Maine Bureau of Insurance notified CMI that under Maine's workers' compensation law employers may satisfy their workers' compensation benefit obligations either by purchasing liability insurance from an insurer authorized to do business in Maine or by securing authorization from the Bureau to self-insure.[1]

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[1] 39-A M.R.S.A. § 403(1) provides, in relevant part, that "[t]he employer may comply with this section by insuring and keeping insured the payment of such compensation and other

The Bureau made clear to the plaintiff that it did not approve CMI's subscription to the Plan as a discharge of its obligations under the workers' compensation law. CMI contends that the state's attempted regulation of its workers' compensation scheme represents an intrusion into the administration of an employee benefit plan covered by ERISA that is preempted by federal law. Memorandum of Law in Support of Plaintiff's Motion for Preliminary Injunction ("Plaintiff's Memorandum") at 5, 10-18 (Docket No. 4). The Superintendent asserts that the Plan does not qualify as an ERISA-covered plan but that, even if it does, Maine's workers' compensation law does not "relate to" it and so is not preempted by ERISA. Defendants's [sic] Objection and Memorandum of Law in Opposition to Plaintiff's Motion for Preliminary Injunction ("Defendant's Memorandum") at 7, 20 (Docket No. 11).

STANDARD OF REVIEW

In evaluating the plaintiff's entitlement to a preliminary injunction, the court must consider four factors, one of which is the likelihood of success on the merits. *Narragansett Indian Tribe v. Guilbert*, 934 F.2d 4, 5 (1st Cir.

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benefits under a workers' compensation insurance policy." Section 403(3) provides the option of self-insurance. It states, in part, "The employer may comply with this section by furnishing satisfactory proof to the Superintendent of Insurance of solvency and financial ability to pay the compensation and benefits, and depositing cash, satisfactory securities, irrevocable standby letters of credit issued by a qualified financial institution or a surety bond with the board, in such sum as the superintendent may determine. . . . " 39-A M.R.S.A. § 403(3).

1991); *see also Augusta News Co. v. News America Publishing, Inc.*, 750 F.Supp. 28, 31 (D. Me. 1990). With the consent of the parties, I agreed that the court would bifurcate is consideration of the ERISA preemption question which is at the heart of this litigation. Because the Superintendent contends that the Plan is not one covered by ERISA and that additional discovery would be required before that issue could be determined, it was agreed that the court would decide the following question first: Assuming, *arguendo*, that the Plan is a so-called ERISA employee benefit plan, is Maine's workers' compensation law preempted by ERISA? *See* endorsement on Plaintiff's Motion to File Reply Memorandum (Docket No. 15). An affirmative answer will next require consideration of the Superintendent's assertion that the Plan is not an ERISA plan. A negative answer will foreclose the plaintiff from the relief it is seeking and necessarily terminate this litigation. In this agreed posture, then, the court effectively now has before it a defendant's motion to dismiss for failure to state a claim upon which relief can be granted.[2]

LEGAL ANALYSIS

ERISA establishes a comprehensive system for the federal regulation of private employee benefit plans, including both pension and welfare plans. 29 U.S.C. § 1002. Section 1144(a) of ERISA provides that all state

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[2] Although both sides have submitted affidavits, it is not necessary to go beyond the allegations of the complaint to establish the factual framework necessary to a first-stage consideration of the preemption question as agreed upon.

laws shall be superseded "insofar as they now or hereafter relate to any employee benefit plan described in section 1003(a) and not exempt under section 1003(b)[3]. . . . " a state law "relates to" an employee benefit plan "if it has a connection with or reference to such a plan." *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Courts have been particularly critical of state laws which specifically refer to ERISA plans and single them out for special treatment. *McCoy v. Massachusetts Inst. of Technology*, 950 F.2d 13, 18 (1st Cir. 1991), *cert. denied*, 112 S. Ct. 1939 (1992). However, ERISA preempts state law which "relates to" covered plans " 'even if the law is not specifically designed to affect such plans, or the effect is only indirect' " *Greater Washington Bd. of Trade*, 113 S. Ct. at 583 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990)) and even if the law is " 'consistent with ERISA's substantive requirements' " (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)).

While the Court has emphasized the expansive nature of ERISA preemption, its reach is not unlimited.

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[3] 42 U.S.C. § 1003(b) provides for exemption from ERISA coverage in limited circumstances, including those in which a plan is maintained solely for the purpose of complying with applicable workers' compensation laws or unemployment compensation or disability insurance laws. 42 U.S.C. § 1003(b)(3). Although the defendant suggests that there is an absence of evidence that CMI's workers' compensation program is combined significantly with other benefit programs, I will assume for purposes of this motion that it does not qualify for this exemption.

"Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. The distinction between state laws that "relate to" employee benefit plans and those that do not is far from clear. The First Circuit has suggested that where "gray areas" exist, the court should look to the policy rationales behind ERISA and its preemption clause, which include protection of the rights and expectations of plan participants and assurance that plans are subject to a uniform body of benefit law with minimal administrative and financial burdens of compliance with conflicting state and federal directives. *McCoy*, 950 F.2d at 17-18.

Other circuits have provided some guidance for evaluating "gray area" statutes. Comparing cases in which ERISA preemption was found to occur with those in which it was not, the Second Circuit concluded that preempted laws "are those that provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee." *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989). Those that are not preempted are "laws of general application – often traditional exercises of state power or regulatory authority – whose effect on ERISA plans is incidental." *Id.* "What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit." *Id.* at 146-47.

Similarly, the Ninth Circuit has grouped state statutes held preempted because they "relate to" ERISA plans into four categories: 1) laws that regulate the type of benefits or terms of ERISA plans; 2) laws that create reporting, disclosure, funding or vesting requirements for ERISA plans; 3) laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans; and 4) laws and common-law rules that provide remedies for misconduct resulting from the administration of ERISA plans. *Martori Bros. Distrib. v. James-Massengale*, 781 F.2d 1349, 1356-58 (9th Cir.), *cert. denied*, 479 U.S. 949 (1986). The court noted that the principle underlying all of the decisions finding preemption is that the state law regulates matters controlled by ERISA: disclosure, funding, reporting, vesting and enforcement of benefit plans. *Id.*

A recent application of the *Aetna Life* and *Martori Bros.* framework appears in *Employee Staffing Servs., Inc. v. Aubry*, No. C-92-4096 SAW, 1993 U.S. Dist. LEXIS 3948 (N.D. Cal. Mar. 17, 1993), a case strikingly similar to the one here before the court inasmuch as it too involved the question whether a state workers' compensation statute is preempted by ERISA.[4] In reviewing California's workers'

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[4] Section 3700 of California's Labor Code is similar to 39-A M.R.S.A. § 403 in that it provides that every private employer must secure the payment of workers' compensation by either obtaining insurance with an approved insurer or by receiving approval from the Director of Industrial Relations to self-insure. Approval is contingent upon the employer's furnishing proof of the ability to self-insure and to pay any compensation that may become due to its employees. Cal. Lab. Code § 3700(a), (b). In *Employee Staffing Services*, the plaintiffs claimed that because they provided their employees with workers' compensation benefits though an ERISA-covered plan, ERISA preempted state regulation.

compensation statute against the *Martori Bros.* standard, the court stated:

> The law is one [of] general application, and involves a traditional exercise of state power. It does not: provide for alternative causes of action for employees to collect benefits protected by ERISA; refer to ERISA plans; apply solely to ERISA plans; nor interfere with the calculation of benefits owed to employees. Further, it does not: regulate the benefits or terms of ERISA plans; create any reporting, disclosure, funding, or vesting requirements; provide rules for the calculation of benefits; nor provide remedies for misconduct arising from the administration of ERISA plans. Rather, the California Workers' Compensation law only requires that California employers purchase workers' compensation insurance or meet the state's requirements for self-insurance. Plaintiffs may comply with the state law without altering the [employee benefit] plan.

Id. at *11-*12. The court concluded that the law thus does not "relate to" an ERISA-covered employee benefit plan and therefore is not preempted. *Id.* at *12.

Exposing Maine's workers' compensation law to similar scrutiny compels the same conclusion. It is apparent from the language of section 403 that its purpose is to guarantee the solvency of workers' compensation plans. The statute applies to all private employers, not just those who have adopted employee benefit plans covered by ERISA. It is not directed toward changing the rights or expectations of employee benefit plan participants. The plaintiff may comply with state law without altering its employee benefit plan although, admittedly, there may be

duplication or increased cost. However, many state laws indirectly affect the cost of administering ERISA-covered plans but in doing so do not trigger ERISA preemption. *See Aetna Life*, 869 F.2d at 146 (where state statute does not affect structure, administration or type of benefits provided by ERISA plan, mere fact statute has some economic impact on plan does not require it be invalidated). As the Second Circuit has stated, "[I]f ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, these plans will be permitted a charmed existence that never was contemplated by Congress." *Rebaldo v. Cuomo*, 749 F.2d 133, 138-39 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

CONCLUSION

For the foregoing reasons, I recommend that the plaintiff's motion for preliminary injunction be *DENIED* and that the action be *DISMISSED*.

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) for which de novo review by the district court is sought, together with a supporting memorandum, within ten (10) days after being served with a copy thereof. A responsive memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to de novo review by the district court and to appeal the district court's order.

Dated at Portland, Maine this 15th day of June, 1993.

/s/ David M. Cohen
David M. Cohen
United States
Magistrate Judge

OFFICE OF THE CLERK
United States District Court
DISTRICT OF MAINE

WILLIAMS S. BROWNELL
CLERK

Edward T. Gignoux U.S. Courthouse
156 Federal Street, Rm. 102
Portland, Maine 04101
Tel. (207) 780-3356

March 29, 1993

To: All Counsel of Record

Re: Combined Management v. Insurance, ME Supt.
Civil No. 93-39-P-H

Dear Counsel:

Kindly be advised that plaintiff's motion to file reply memorandum was endorsed as follows:

> 3/29/93 Granted in part as follows. During a telephone conference with counsel this date, it was agreed that the following threshold issue presented by this case should be decided first: Assuming, arguendo, that the plan of the International Association of Entrepreneurs of America ("IAEA"), through which the plaintiff allegedly provides a variety of benefits to its employees, is a so-called ERISA employee benefit plan, is Maine's workers' compensation law preempted by ERISA? Plaintiff shall have to an [sic] including 4/12/93 within which to file a reply memorandum of not more than 15 pages addressing this issue only. The parties agree that no additional evidentiary materials need be presented on the issue. The threshold issue as framed shall be decided on the papers filed to date and the plaintiff's reply memorandum to

be filed. if [sic] the question presented is answered in the affirmative, the court will confer with counsel concerning additional filings to be made to complete the evidentiary record and briefing on remaining issues relating to qualification of the IAEA plan for ERISA protection. /s/ David M. Cohen, USMJ.

Sincerely,

/s/ Kimberly A. Diamond,
Kimberly A. Diamond,
Deputy Clerk

cc: Ralph Dyer, Esq.
James Bowie, Esq.

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

COMBINED MANAGEMENT, INC.,	)
Plaintiff,	)
-versus-	)
BRIAN K. ATCHISON,	)
Defendant.	)

AFFIDAVIT OF RICHARD SPUGNARDI

Now comes Richard Spugnardi, who being duly sworn, hereby deposes and says as follows:

1. Affiant is a principal of Combined Management, Inc. ("CMI") and is responsible for the business operations of the corporation, including the provision of medical and other benefits to its employees.

2. CMI is engaged in the business of employee leasing and is duly registered in the State of Maine pursuant to 32 M.R.S.A. Sec. 14052, et seq.

3. CMI is an "employer" as defined by 29 U.S.C. Sec. 10025. CMI employs individuals and leases their services on a long-term basis to persons, associations, partnerships, corporations or other entities pursuant to written contracts.

4. CMI pays the wages of its employees leased to client companies, withholds and remits State and Federal taxes as required by applicable law and provides its leased employees with a variety of employee welfare benefits, including medical and surgical coverage, dental

coverage, vision care coverage and accidental death and dismemberment coverage.

5. These benefits are provided through a subscription by CMI to the International Association of Entrepreneurs of America Welfare Benefit Plan (the "Plan"). This is a multi-employer welfare benefit plan as defined by 29 U.S.C. Sec.s 1002(3) and 1002(37)(A). A summary of the Plan was filed with the Department of Labor pursuant to the ERISA requirements in December, 1992.

6. The Plan is established and maintained by the International Association of Entrepreneurs of America Trust (the "Trust") for the benefit of the employees and dependents of members of the International Association of Entrepreneurs of America (the "IAEA Association").

7. Among the benefits provided to the employees of CMI are occupational injury and illness benefits mandated by the Maine Workers' Compensation Act of 1992. Such benefits are described in Articles 18 and 19 of the Plan.

8. CMI pays a portion of the Plan's required premium for coverages for the employees and each respective employee can make a contribution to obtain various optional benefits. CMI pays the entire premium for any work related injury and illness coverages as well as the basic medical coverage. Employees pay for elected, optional benefits.

9. The benefits provided by the Plan are administered as a coordinated, integrated package. Occupational injury and disability are neither separately insured nor

separately administered. All claims for benefits are subject to the approval of the Plan administrator. Claims are submitted to the administrator for review and for approval or denial. All benefit portions of the Plan, including Workmen's Compensation, are fully re-insured in a single re-insurance package.

10. Affiant has had various communications with representatives of the Bureau of Insurance of the State of Maine. CMI has received notification from the Bureau of Insurance that it does not approve of the program for providing benefits to CMI's employees. It is Affiant's understanding that the Bureau of Insurance now requires CMI to obtain workers' compensation and employers' liability insurance from an insurer authorized to do business in Maine, and that it cease and desist from seeking to provide Workers' Compensation benefits by means of the Plan.

11. A copy of the notification received from the Bureau of Insurance is attached hereto as Exhibit A.

12. A copy of the Plan is attached hereto as Exhibit B.

13. A copy of the Participation Agreement is attached hereto as Exhibit C.

14. CMI presently employs approximately 50 persons who are leased to 11 client companies located in Maine.

15. If the Bureau of Insurance is successful in requiring a separately administered Workmen's Compensation and Employers' Liability program by CMI for the benefit of its employees, CMI will suffer irreparable

injury. The cost of obtaining such Workmen's Compensation insurance is substantially in excess of the cost of similar benefits provided under the IAEA Plan. In addition, this would seriously disrupt the ability of CMI to provide medical and other benefits to its employees. The Plan is an integrated and coordinated package and if CMI is required to provide separate Workmen's Compensation and Employers' Liability insurance it will necessarily result in redundant benefits at an excessive cost to CMI. In addition, the Maine Workmen's Compensation Act of 1992 provides that a failure to secure insurance as deemed necessary by the Bureau of Insurance constitutes a Class D crime and liability for a civil penalty of up to $10,000 as well as revocation of CMI's authorization to do business in the State of Maine.

16. The Plan meets all of the requirements for occupational health and disability benefits as mandated by the Workmen's Compensation Act of 1992.

17. This Plan is in full force and effect. The Plan now covers more than 3,000 employees throughout the United States and has more than 40 employer subscribers.

18. There is no indication that any employee of CMI located in the State of Maine will suffer any disadvantage, harm or prejudice by reason of the continuation of the benefits through and by means of the IAEA Plan.

Dated: February 10, 1993

/s/ Richard Spugnardi
Richard Spugnardi

VERIFICATION

February 10, 1993

STATE OF MAINE
Cumberland, ss.

On this date, there appeared before me the above named Richard Spugnardi, to me personally known, who, being duly sworn, did state under oath the foregoing Affidavit to be true and correct.

/s/ Barbara Ann Willicka
Notary Public/
Attorney At Law

BARBARA ANN WILLICKA
NOTARY PUBLIC, MAINE
MY COMMISSION EXPIRES
AUGUST 27, 1999

EXHIBIT
A

John R. McKernan, Jr.
Governor

Brian K. Atchinson
Superintendent

(Seal)

DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
(207) 582-8707
Telecopier (207) 582-8716

January 29, 1993

Michael Peterson
Combined Management, Inc.
15 Lincoln St.
Lewiston, Maine 04240

RE: Independent Association of Entrepreneurs of America (IAEA)

Dear Mr. Peterson:

This letter is in confirmation of and to follow-up on our telephone conversation of January 25. As I understand it, you acknowledge soliciting a benefit program which is in some way associated with the referenced association. You portrayed the program as an alternative to workers' compensation for employers as well as providing further health care benefits. You represented that your belief is that the program is federally approved.

I want to make sure that you are absolutely clear that our conversation leaves me with serious and substantial concerns regarding your program. Under the Maine Workers' Compensation Act, Maine's employers have

two methods of securing their obligations; they may purchase a workers' compensation and employers liability insurance policy from an authorized insurer or they may secure authorization to self-insure from the Bureau of Insurance. *No other alternatives to secure obligations are permissible.* Workers Compensation is a system which is based entirely on laws enacted by the States, and the federal government does not approve or authorize insurers to transact workers' compensation coverage or employers to self-insure in the States. As it appears that your program contemplates neither of the above methods, I have no option other than to conclude that a substantial issue exists. Furthermore I am told that, based upon your representations, various employers are cancelling valid workers' compensation coverage otherwise in force.

You compared your program to those of Bath Iron Works and The Ceres Corporation. I would again note to you that this is not a valid comparison. Bath Iron Works is an authorized self-insurer. The Ceres Corporation caused policies of workers compensation insurance to be issued with respect to its' [sic] clients.

I have further concerns concerning the health benefit portion of the program you are offering. Your explanations give rise to the question as to whether the program is an uninsured multiple employer welfare arrangement (MEWA) which would be deemed to be acting as an unauthorized insurer under Maine law.

Upon your referral, I spoke with John Geismar, Esq., of Isaacson & Raymond. He was neither able to satisfy any of my concerns nor to clarify for me the nature of the

underlying IAEA program. It is my understanding that you have not received a favorable opinion regarding its' [sic] legality from him. If you are of a contrary view, I would suggest that your further consultation with him may be in your interest. If any such consultation should lead to Mr. Geismar's comfort level with the program and your actions being enhanced, I would ask that he contact this office so that any concerns we may have may be addressed.

This letter does not constitute a formal Order or action of the Superintendent of Insurance. I want you to be perfectly clear, however, that at this time you should not consider the program you are soliciting to enjoy either the explicit or implicit approval of this office and that any actions you engage in in furtherance of the program are done so at your own risk of adverse action by this office.

You will be contacted further by an investigator from this office in the near future.

Sincerely,

/s/ Thomas M. Record
THOMAS M. RECORD, Esq.
Staff Attorney

cc John Geismar, Esq.

EXHIBIT
B

INTERNATIONAL ASSOCIATION OF ENTREPRENEURS OF AMERICA BENEFIT TRUST EMPLOYEE WELFARE BENEFIT PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION PLAN NO. 501

THE INTERNATIONAL ASSOCIATION OF ENTREPRENEURS OF AMERICA BENEFIT TRUST EMPLOYEE WELFARE BENEFIT PLAN

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THE INTERNATIONAL ASSOCIATION OF ENTREPRENEURS OF AMERICA BENEFIT TRUST

EMPLOYEE WELFARE BENEFIT PLAN

This constitutes the Plan Document and Summary Plan Description for the **International Association of Entrepreneurs of America Employee Welfare Benefit Plan** (the "Plan"). The Plan was established and is maintained by the International Association of Entrepreneurs of America Benefit Trust, for the benefit of the employees and dependents of members of the **International Association of Entrepreneurs of America** (the "**Association**"), which has elected to provide benefits under the Plan. The Plan conforms to and is governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan is not a policy of insurance. Neither the **Association**, nor the Trust, is an insurance company.

The Plan makes available two (2) alternative schedules of Major Medical Benefits, designated herein as Schedule II and Schedule III. Plan Participants may choose to be covered under either schedule. Plan Participants are eligible for benefits under only one of the schedules, however.

The Plan makes available to all employees occupational injury and illness benefits as described herein.

The Plan further makes dental care benefits and vision benefits available, on an optional basis, to those Participants who have chosen to be covered under Schedule III. Participants who wish to choose the dental care benefits and vision benefits must make application for such and pay all required contributions to the Plan Administrator.

Plan Administrator:

International Association of Entrepreneurs of America
1520 W. Airport Freeway, Suite 102
Irving, Texas 75062
(214) 259-1944
Employer Identification Number 75-2456927

ARTICLE 1.
DEFINITIONS

The following terms as used in this Plan Document shall have the meanings as described herein.

1.1 Accident. An unforeseen and unavoidable event resulting in an injury which is not due to any fault of the covered person.

1.2 Association. The term "**Association**" means **The International Association of Entrepreneurs of America**.

1.3 Benefit Year. The term "Benefit Year" means a period of twelve consecutive months beginning each January and running through the following December. The terms Benefit Year and Year are used interchangeably in this **Plan**.

1.4 Claims Adjuster. The term "Claims Adjuster" means any person or entity designated, appointed and employed by the Committee or the Plan Administrator to verify eligibility, administer the payment of claims for reimbursement, and who engages in other routine and non-discretionary administrative functions in accordance with the terms of the Trust and this **Plan**.

1.5 Benefit Review Committee. The term "Benefit Review Committee" or "BRC" means the governing body that oversees the operation of the **Plan**, according to the Agreement and Declaration of Trust. Its members are appointed by the **Association**.

1.6 COBRA. The term "COBRA" refers to the Comprehensive Omnibus Budget Reconciliation Act of 1986, as amended, which provides for continuation coverage for qualified beneficiaries.

1.7 Employer. The term "Employer" means each employer which is a member of the **Association** and which has, or may hereafter, adopt the **Plan** with respect to its employees.

1.8 ERISA. The term "ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended.

1.9 Home Health Care Agency. The term "Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

(A) It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provided [sic] skilled nursing services and other therapeutic services;

(B) It has policies established by a professional group associated with the agency or organization. This professional group must include at least one physician and at least one registered nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a physician or R.N.;

(C) It maintains a complete medical record on each individual; and

(D) It has a full-time administrator.

1.10 Hospital. The term "Hospital" means a licensed accredited general hospital, which has full diagnostic, surgical and therapeutic facilities under the supervision of a staff of physicians, and regularly provides 24 hour nursing service by registered nurses or licensed practical nurses. Institutions maintained for care of the aged, rest or nursing homes, or other extended care facilities are not considered Hospitals within the meaning of the **Plan**.

1.11 Illness. The term "Illness" means a bodily disorder, disease, physical sickness, mental infirmity, or functional disorder of covered person, which does not arise, and which is not caused or contributed to by, or as a

consequence of, any employment or occupation for compensation or profit. A recurrent illness will be considered an illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered an illness.

1.12 Injury. The term "Injury" means a condition caused by accidental means which results in damage to the covered person's body from an external force, but which does not arise, and which is not caused or contributed to by, or as a consequence of, any employment or occupation for compensation or profit.

1.13 Medically Necessary. The term "Medically Necessary" means health care services, supplies or treatment which, in the judgment of the attending physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

1.14 Participant. The term "Participant" means each person who is or may be entitled to receive benefits under this **Plan** and who is in the employ of an Employer which has adopted the **Plan** with respect to its employees.

1.15 Occupational Illness or Injury. The term "Occupational Illness or Injury" means an on-the-job illness or injury which occurs in the course and scope of employment, in furtherance of the business of the employer, or is caused or aggravated thereby. Benefits for Occupational

Illness or Injury are sometimes referred to herein as workers' compensation benefits.

1.16 Outpatient Facility. A medical facility outside of a hospital setting, or at a hospital if room and board charges are not incurred.

1.17 Physician. A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), or Doctor of Podiatry Medicine (D.P.M.), or Doctor of Chiropractic (D.C.), and who is legally entitled to practice medicine in all its branches under the laws of the state where the services are rendered.

1.18 Physiotherapy. The treatment of disease, injury, etc. by physical means rather than with drugs, such as by exercises, massage, infrared or ultraviolet light, electrotherapy, hydrotherapy, or heat.

1.19 Plan. The term "**Plan**" means **The IAEA** Employee Welfare Benefit Plan as set forth in this document, together with all amendments or modifications made to it.

1.20 Plan Administrator. The term "Plan Administrator" means the Committee of the **Plan** or, alternatively, where designated, appointed and employed the by the Committee, in writing, an agent, whether a legal entity or a person, who shall, prior to said designation, appointment and employment, acknowledge in writing such agent's fiduciary status with respect to the **Plan** and shall accept the position of Plan Administrator.

1.21 Recognized Charges. The term "Recognized Charges" refers to usual, customary and reasonable health care expenses which result from an Illness or Injury not related to employment. Such charges must be for services and supplies which are Medically Necessary.

The **Plan** uses certain guidelines to determine Recognized Charges. For all expenses (such as Hospital expenses, doctors, laboratory, supplies, etc.), the Recognized Charge allowed under the **Plan** is based on the reasonable and customary allowance, which may be adjusted periodically by the Board of Trustees.

Whenever possible, Participants should discuss charges with their doctor or other service provider in advance so that they are aware of any portion of the charges that will not be reimbursed to them by the **Plan**.

1.22 Rehabilitation. Constructive activity by mechanical and/or physical (not psychological) therapy to restore a normal state of health.

1.23 Trust. The term "Trust" means the trust established by the Association pursuant to the **Plan**, and any other trust or fund established hereunder, as well as any modification, amendment, extension or renewal thereof.

1.24 Workers' Compensation Law. The term "Workers' Compensation Law" means the benefits applicable under the workers' compensation law and occupational disease law of the state or territory, including the District of Columbia, in which your Employer's work place or work places are located.

The term "Workers' Compensation Law" includes amendments to that law in effect on the date the Occupational Illness or Injury occurs. It does not include the provisions of any law that provides non-occupational disability benefits. It also does not include the Longshore and Harbor Workers Compensation Act (33 U.S.C. §§ 901-950) or any amendment thereto.

ARTICLE 2.
GENERAL CONTRIBUTION PROVISIONS

2.1 Employee Contribution:

Coverage is provided in return for payment of the required contribution for the various benefits available hereunder. Contribution rates are determined from time to time by the Plan Administrator. Employees are thereafter responsible for the payment of all contributions when due. Coverage for all benefits will terminate if the required contribution is not paid to the Plan Administrator.

2.2 Contribution Computation:

Each Contribution will be determined by applying the appropriate rate shown in the applicable table of contribution rates. Contributions for benefits are based on area classification, actual age, Deductible amount, any optional benefits chosen, and whether the coverage is for the Employee only or for Dependents also.

2.3 Contribution Payments:

Contributions are due and payable in advance. Contributions are payable to the Administrator or to its designated representative for the collection of contributions.

All contributions are due on or before the first day of the Contribution Month for which payment has not been made.

The Employee is liable for all unpaid contributions. If the required contribution is not paid on or before the expiration of thirty-one (31) days after the contribution due date, coverage for Covered Persons for whom the Contribution has not been paid will end.

2.4 Change in Contribution:

The Plan reserves the right to change the contribution rates on any contribution due date on or after three (3) months following the date the Plan is adopted. The Plan will notify the Employees in writing of any change in their Contribution rate 30 days in advance of such change.

2.5 Misstatement of Age:

If the age of a Covered Person is misstated, the contribution rate will be adjusted to the correct age. If the age is misstated and the Covered Person was not eligible for coverage under this Plan, the Plan liability will be limited to a return of the contribution paid on behalf of such Covered Person, without interest.

ARTICLE 3.
SCHEDULE OF MAJOR MEDICAL BENEFITS – SCHEDULE II

IMPORTANT – PLEASE NOTE: This Schedule of Benefits is for Participants who choose benefits under Schedule II, and who make the appropriate contributions for such coverage. Benefits described herein, whether

expressed in dollars or as a percentage amount, are payable only for Recognized Charges for Medically Necessary services and supplies. Charges in excess of Recognized Charges are for services and supplies which are not Medically Necessary are not covered by this **Plan**.

CAUTION: Covered persons must comply with the pre-admission certification requirements for any Hospital stay. Before any Hospital confinement, read the Pre-Admission Certification (PAC) and Continued Stay Review (CSR) requirements of this Plan Document. Failure to follow these pre-admission certification requirements may result in a 50% reduction in payable benefits.

Specific limitations and conditions may apply, depending on the service supplied or procedure performed. These limitations and conditions are described elsewhere in this Plan Document.

3.1 Deductible:

Per Individual	$250 per Accident or Sickness
Per Family	$750 per Accident or Sickness

3.2 Lifetime Maximum for Major Medical Benefits:

Per Individual	$1,000,000

3.3 Reimbursement Percentage:

Per Individual	50% of First $2000; 100% thereafter for each Accident or Sickness, up to any Plan maximums

3.4 Maximum Out-Of-Pocket Expense:

Per Individual	$1,000 (plus deductible)
Per Family	$3,000 (plus deductible)

3.5 Hospital Benefits:

(A) Room and Board:

Daily Limit	The hospital's standard semi-private room rate
Maximum	120 days per person

3.6 Various limitations and Maximums:

Failure to pre-certify may reduce benefits up to 50% with a maximum out-of-pocket penalty of $7,500. See the Pre-Admission Certification and Continued Stay Review procedures elsewhere in this Plan Document.

Maximum chronic illness benefit is 50 days lifetime, but no more than $15,000 of recognized charges in any 12 month period, $25,000 lifetime, per person.

Maximum communicable disease benefit is 50 days lifetime, but no more than $15,000 of recognized charges in any 12 month period, $25,000 lifetime, per person.

Maximum Magnetic Resonance Imaging (MRI) benefit is $750 per illness or injury, including all ancillary and modality charges.

Maximum Mental and Nervous Conditions benefit is maximum of 30 days but no more than $10,000 of recognized charges in any 12 month period, $10,000 lifetime, per person.

Maximum physiotherapy and rehabilitation benefits are maximum of 30 days, inpatient, in any 12 month period, $10,000 lifetime, per person.

Maximum Hospice Care benefit is $10,000 lifetime, per person payable at a maximum of $100 per day.

Charges for care of corns, bunions, (except capsular or bone surgery), calluses, nails of the feet, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet will not be covered unless member has continuous coverage under this **Plan** for 2 years.

Maximum Newborn benefit is maximum of $20,000 lifetime, per person.

Heart Bypass Surgery will have a $50,000 maximum lifetime benefit that is payable at 50%. Neurological Surgery will have a $12,500 maximum lifetime benefit paid at 50%. Chemotherapy and Radiation therapy maximum lifetime benefit is $5,000 payable at $1,250 per calendar year.

Maximum Drug benefit is $1,000 per person, per calendar year.

Injury or accident due to motor cycle riding has a maximum benefit of $10,000.

BENEFITS FOR ACCIDENTS ARE PAYABLE AS OF THE EFFECTIVE DATE FOR THE PARTICIPANT. BENEFITS FOR ILLNESS ARE PAYABLE AFTER THE PLAN HAS BEEN IN EFFECT FOR 30 DAYS.

ARTICLE 4.

SCHEDULE OF MAJOR MEDICAL BENEFITS – SCHEDULE III

IMPORTANT – PLEASE NOTE: This Schedule of Benefits is for Participants who choose benefits under Schedule III, and who make the appropriate contributions for such coverage. Benefits described herein, whether

expressed in dollars or as a percentage amount, are payable only for Recognized Charges for Medically Necessary services and supplies. Charges in excess of Recognized Charges are for services and supplies which are not Medically Necessary are not covered by this **Plan.**

CAUTION: Covered persons must comply with the pre-admission certification requirements for any Hospital stay. Before any Hospital confinement, read the Pre-Admission Certification (PAC) and Continued Stay Review (CSR) requirements of this Plan Document. Failure to follow these pre-admission certification requirements may result in a 50% reduction in payable benefits.

Specific limitations and conditions may apply, depending on the service supplied or procedure performed. These limitations and conditions are described elsewhere in this Plan Document.

4.1 Deductible:

Per Individual	$250 per Plan Year
Per Family	$750 per Plan Year

4.2 Lifetime Maximum for Major Medical Benefits:

Per Individual	$1,000,000

4.3 Reimbursement Percentage:

Per Individual	80% of First $5000; 100% thereafter, up to any applicable maximums

4.4 Maximum Out-Of-Pocket Expense:

Per Individual	$1,250 per Plan Year
Per Family	$3,750 per Plan Year

4.5 Hospital Benefits:

(A) Room and Board:

Daily Limit	The hospital's standard semi-private room rate
Maximum	120 days per person

4.6 Various limitations and Maximums:

Failure to pre-certify may reduce benefits up to 50% with a maximum out-of-pocket penalty of $7,500. See the Pre-Admission Certification and Continued Stay Review procedures elsewhere in this Plan Document.

Maximum chronic illness benefit is 50 days lifetime, but no more than $15,000 of recognized charges in any 12 month period, $25,000 lifetime, per person.

Maximum communicable disease benefit is 50 days lifetime, but no more than $15,000 of recognized charges in any 12 month period, $25,000 lifetime, per person.

Maximum Magnetic Resonance Imaging (MRI) benefit is $750 per illness or injury, including all ancillary and modality charges.

Maximum Mental and Nervous Conditions benefit is maximum of 30 days but no more than $15,000 of recognized charges in any 12 month period, $15,000 lifetime, per person.

Maximum physiotherapy and rehabilitation benefits are maximum of 30 days, inpatient, in any 12 month period, $10,000 lifetime, per person.

Maximum Hospice Care benefit is $10,000 lifetime, per person payable at a maximum of $100 per day.

Charges for care of corns, bunions, (except capsular or bone surgery), calluses, nails of the feet, flat fleet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet will not be covered unless member has continuous coverage under this **Plan** for 2 years.

Neurological Surgery will have a $12,500 maximum lifetime benefit paid at 50%.

Injury or accident due to motor cycle riding has a maximum benefit of $10,000.

BENEFITS FOR ACCIDENTS ARE PAYABLE AS OF THE EFFECTIVE DATE FOR THE PARTICIPANT. BENEFITS FOR ILLNESS ARE PAYABLE AFTER THE PLAN HAS BEEN IN EFFECT FOR 30 DAYS.

ARTICLE 5.
COVERED MAJOR MEDICAL EXPENSES

The **Plan** allowances for treatment of an Illness or Injury are for the following services and supplies:

5.1 Medical treatment by a licensed physician. Certain visits may not be payable if the **Plan** pays a surgical benefit since that allowance includes pre-operative and post-operative care by the physician.

5.2 Specialist consultation if the covered individual is referred to a qualified (Board Certified) medical specialist by the physician.

5.3 Surgical treatment by a legally qualified physical [sic] or surgeon The **Plan** surgical allowance includes post-operative care by the physician.

5.4 Anesthesia by a professional anesthesiologist.

5.5 X-Ray and laboratory services.

5.6 Radiation therapy, including radioactive substances, and/or chemotherapy.

5.7 Hemodialysis.

5.8 Physiotherapy by a licensed physiotherapist.

5.9 In-hospital private duty nursing by a registered nurse (R.N.), for up to 15 shifts (one shift equals up to 8 hours) per person per Benefit Year. Medical need for private duty nurses must be substantiated by a physician.

5.10 Hospital clinic and other outpatient services (except as otherwise specified for ambulatory surgery and pre-admission testing).

5.11 Local professional ambulance transportation to or from the Hospital, and if the Illness or Injury requires special and unique Hospital treatment, up the amount set forth in the Schedule of Benefits for transportation (by professional ambulance, railroad or commercial airline on a regularly scheduled flight) within the United States or Canada to the nearest Hospital equipped to furnish the treatment.

5.12 Drugs and medicines which require a physician's written prescription unless the Participant is entitled to benefits from any other prescription benefit program, then benefits are payable under that program.

5.13 Insulin and syringes for treatment of diabetes.

5.14 Blood or blood plasma and its administration.

5.15 Rental (up to the purchase price) or purchase of basic prosthetics, crutches, wheelchairs and other necessary medical equipment, appliances and supplies authorized by a licensed physician for a specific Illness, Injury or loss of limb occurring while eligible for benefits under this **Plan.** Benefits are not payable for air conditioners, air purifiers, motorized transportation equipment, escalators or elevators, swimming pools, and the like.

5.16 Dental services provided within the first six months after accidental injury to sound natural teeth, for treatments needed as a result of the accident, including: one oral examination with necessary x-rays, tooth extraction, root recovery, tooth replantation, alveoloplasty, open reduction, including splinting to stabilize teeth, care for fractures or dislocation of the jaw, and general anesthesia; crowns, root canal therapy and dentures; surgical excision of an impacted tooth. No other dental services are eligible.

5.17 Charges for Magnetic Resonance Imaging (MRI), as limited in the Schedule of Benefits.

ARTICLE 6.

DESCRIPTION OF MAJOR MEDICAL BENEFITS

6.1 General:

The **Plan** pays Major Medical Benefits pursuant to either Schedule II or Schedule III herein, but only for Recognized Charges for Medically Necessary services and supplies; charges in excess of Recognized Charges, or for services or supplies which are not Medically Necessary, are not covered by the **Plan.** Specific limitations and

conditions, as described elsewhere in this Document, may apply, depending upon the type of service or benefit; and covered persons must comply with the Pre-Admission Certification requirements before any Hospital stay for the Major Medical Benefits under this **Plan.** Failure to do so may substantially reduce, or eliminate, benefits under the **Plan.**

6.2 Major Medical – Limitation for Pre-existing Conditions:

A Pre-existing Condition means a disability or illness which manifested itself prior to the effective date of a Participant's coverage under this **Plan.** A disability or illness shall be considered to have been in existence prior to the effective date of coverage, if, during that time:

(A) any professional advice or treatment by a physician or other practitioner of the healing arts, or any medical supply (including but not limited to prescription drugs or medicines) was obtained for that disability or illness, or,

(B) the disability or illness was manifest or active, or

(C) there was a distinct symptom or condition from which one learned in medicine could with reasonable accuracy have diagnosed the disability or illness.

6.3 Deductible Amount:

The deductible is the amount of Recognized Charges which you pay before you are entitled to the major medical benefits. The deductible amount under Schedule III is $250.00 annually per each Participant and each dependent.

Only one deductible applies if two or more eligible family members are injured in the same accident.

The maximum number of family deductibles is three per family per **Plan** year; however, any recognized charges which you pay in the last quarter of the Plan Year that are applied to the deductible amount but do not equal the deductible amount, are carried over to the next Plan Year and will apply to the deductible amount for that year.

6.4 Plan Payment:

Except where otherwise indicated in this section, the **Plan** pays 80% of Recognized Charges in excess of the deductible amount until you have met your out-of-pocket maximum. See the Summary of Benefits for your out-of-pocket maximum. Thereafter, the **Plan** will pay 100% of Recognized Charges. The Participant is responsible for the balance. All charges which are not Recognized Charges and/or charges in excess of **Plan** limitations are the responsibility of the Participant.

Whenever possible, discuss fees and charges with doctors and other health care providers before treatment. It is in your best interest to discuss fees and charges and to review each bill to ensure that it complies with these discussions.

6.5 Hospital Care:

The **Plan** will generally pay for up to 365 days per covered person per Benefit Year for Medically Necessary Hospital confinement due to Illness or Injury.

Many non-emergency procedures and treatments can now be performed using the Hospital's outpatient facilities (operating room, recovery room, cystoscopy room, etc.) so that an overnight stay can be avoided. Claims are reviewed and days that are determined by the designated review organization to not be Medically Necessary will be denied for coverage purposes.

Discuss the diagnosis with the doctor to make sure that each day in the Hospital is necessary.

The Plan Administrator at its discretion, may limit the number of recognized Hospital days for a given Illness based upon the diagnosis and course of treatment.

6.6 Hospital Confinement:

If you or an eligible dependent are admitted to a Hospital, advise the admitting office of the Hospital of your **Plan** coverage. The Hospital will initiate the claim with the **Plan.** If there is coverage by any other health Plan, inform the admitting office.

6.7 Private Room Accommodations:

The **Plan** does not pay for private room charges. If a private room is used, the **Plan** will only pay the average per diem charge for semi-private confinement at other Hospitals in the geographic area adjacent to the confining Hospital. The Participant will be responsible for the entire difference between the average semi-private room charge and the charge for the private accommodations.

6.8 Travel Outside of the U.S.:

No benefits are payable for Injury occurring or Illness contracted while traveling outside of the United

States except on a temporary basis, not to exceed 60 contiguous days of travel.

6.9 Newborn Children:

Under a family membership, benefits available from birth for:

(A) The treatment of Illness or Injury, or

(B) Nursery Care in an approved premature unit for an infant weighing less than 2.500 grams (5.5) pounds, or

(C) Incubator care, regardless of the infant's weight.

6.10 Mental and Nervous Conditions and/or Substance Abuse:

The **Plan** pays limited benefits, as set forth in he [sic] Schedule of Benefits, for treatment of mental and nervous conditions and/or substance abuse; but please note that substance abuse benefits are payable only for treatment at an approved inpatient or outpatient substance abuse facility. **PAC AND CSR APPROVAL FOR THIS BENEFIT IS REQUIRED.**

6.11 Limitation of Benefits for Chronic Illness:

Benefits for treatment of Chronic Illness such as asthma, allergy, sickle cell anemia, Tay-Sachs disease, or any other chronic condition are limited as specified in the Schedule of Benefits.

6.12 Communicable Diseases:

Benefits for treatment of communicable diseases such as acquired immune deficiency syndrome (AIDS), herpes,

poliomyelitis, venereal disease, etc. are also limited as specified in the Schedule of Benefits.

6.13 Admission Services:

Services by a doctor or agency for interpretation of tests and/or administration of tests routinely ordered by the Hospital as part of the Hospital admitting process are eligible under Major Medical.

6.14 Outpatient Surgery:

The **Plan** will pay benefits for same day surgical facility treatment on the same basis as in-Hospital care providing the surgical facility is equipped comparably to an accredited Hospital facility.

6.15 Physiotherapy and Rehabilitation:

The **Plan** will pay for services of a licensed physiotherapist when such services are required as a result of Injury or Illness resulting in Hospital confinement and the attending physician prescribes physiotherapy or rehabilitation. Such services must be approved by PAC, and the benefits for these is limited, as set forth in the Schedule of Benefits.

6.16 Convalescent Care:

When recommended by PAC or CSR, the **Plan** will pay for charges made by a convalescent nursing facility for the following services and supplies furnished by the facility during the first 120 days of convalescent confinement in any one convalescent period. Only charges incurred in connection with convalescence from the Illness or Injury for which the covered person is confined will be eligible for benefits. These expenses include:

(A) Room and board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as for general nursing services. If private room accommodations are used, the daily room and board charge allowed will not exceed the facility's average semi-private room charge or an average semi-private room charge for confinement at similar institutions in the geographic area adjacent to the institution, whichever is less.

(B) Medical services customarily provided by the convalescent facility with the exception of private duty or special nursing services and physicians' fees.

(C) Drugs, biological, solutions, dressing and casts, furnished for use during the convalescent period, but no other supplies.

6.17 Home Health Care:

These benefits apply to you and your eligible dependents. The **Plan** will pay an allowance, as specified in the Schedule of Benefits, under a home health care plan when recommended by PAC or CSR. The allowance is for charges made by a recognized Home Healthcare Agency for the following:

(A) Part-time or intermittent nursing care by or under the supervision of a registered professional nurse (R.N.) or licensed professional nurse (L.P.N.);

(B) Part-time or intermittent home health aid services which consist primarily of caring for the Member; or

(C) Physical, occupational, and speech therapy, provided by a Home Healthcare Agency.

Home health care benefits are payable only if:

1. A home health care program was established and approved by the attending physician within 7 days following discharge from the Hospital;

2. Home health care commences during such 7 days for the same or related condition which required hospitalization; and

3. The attending physician certified in writing that the proper treatment of the condition would otherwise require inpatient confinement in a Hospital or nursing home that qualifies as a skilled nursing facility as defined Medicare.

6.18 Hospice Care:

Benefits for Hospice Care apply only to a terminally ill Participant (a person who has a life expectancy of 6 months or less), and are limited as specified in the Schedule of Benefits.

6.19 Outpatient Psychiatric Benefit:

The eligible expenses are the charges incurred for the services of an eligible provider are licensed Medical Doctors, licensed psychologists or licensed social workers. These services must be rendered on an outpatient basis, and benefits for these are limited as set forth in the Schedule of Benefits.

Your eligible provider must complete your claim(s) with the exact date(s), including year, on which services were rendered.

This benefit is not subject to the deductible and co-payment provisions set forth in the Summary of Benefits

and does not count for annual out-of-pocket deductibles or co-insurance maximums.

6.20 Ambulance Benefit:

The **Plan** will pay for ambulance service up to the maximum specified in the Schedule of Benefits. This benefit is not subject to the deductible co-payment provisions set forth in the Schedule of Benefits for annual out-of-pocket deductibles or co-insurance maximums.

6.21 Chiropractic Benefits:

THIS BENEFIT IS ONLY AVAILABLE UNDER SCHEDULE III. The **Plan** will pay for chiropractic services, inclusive of all ancillary and modality charges, at up to $20.00 per visit, for a maximum of 15 visits per year. This benefit is not subject to the deductible and co-payment provisions set forth in the Schedule of Benefits and does not apply to out-of-pocket maximums.

ARTICLE 7.
MAJOR MEDICAL EXCLUSIONS

Any service, charge or fee not specifically set forth in this Plan Document is excluded from coverage under the **Plan.** In addition, the following exclusions and limitations apply to Major Medical expenses incurred by all covered persons:

7.1 Hospitalization furnished under Federal, State or other law;

7.2 Care in a veteran's facility or Hospital operated by the United States Government;

7.3 Services and supplies for which no charge is made, or for which the covered person is not legally obligated to pay, or for which no charges would be made in the absence of this coverage;

7.4 Confinement primarily for custodial care or for rest cures or for long-term care;

7.5 Confinement for diagnostic studies, or for cosmetic surgery;

7.6 Charges in excess of what the **Plan** allows as Recognized Charges;

7.7 Eye refractions; eyeglasses, hearing aids and the testing for and fitting thereof;

7.8 Emergency room treatment when services were not necessary to be delivered in emergency room;

7.9 Dental services or confinement for dental services, except those required as a result of an accident occurring while the patient was eligible for benefits under the **Plan**, and rendered within six months of the accident.

7.10 Cosmetic or plastic surgery, all procedures performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to Illness or Injury, or confinement for such surgery or procedures.

7.11 Membership in, or fees, dues or charges incurred with regard to recreational facilities, fitness centers, diet, nutritional or stress management centers, even though prescribed or recommended by a physician.

7.12 Air conditioners, air purifiers, motorized wheelchairs, motorized transportation equipment, escalators or elevators, swimming pools and the like.

7.13 Home health nursing care or hospice or except as otherwise provided in this Plan Document.

7.14 Well-baby care; circumcision before the thirtieth day of life.

7.15 Charges in connection with an Injury or Illness arising out of or in the course of employment for which benefits are payable under workers' compensation laws (benefits may be denied if you or your dependent fail to prosecute a workers' compensation claim).

7.16 Charges for services or supplies which are not consistent with the diagnosis and treatment of a condition.

7.17 Charges for medical services, supplies and treatment unless performed or prescribed as necessary by a legally licensed physician, which for the purposes of medical and surgical benefits under the **Plan** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). However, for treatment of Injury to the mount [sic] or natural teeth due to accident, services of a Doctor of Dental Surgery (D.D.S.) are recognized. For dental and optical benefits, the services of the properly licensed practitioner within the scope of the designated benefits shall also be recognized.

7.18 Charges for which any mandatory automobile no-fault benefits are payable.

7.19 Charges which are in excess of scheduled **Plan** allowances and limitations.

7.20 Charges for testing and treatment of infertility or for artificial insemination or in-vitro fertilization.

7.21 Charges for genetic testing or counseling.

7.22 Charges in connection with dental work or treatment (except as allowed under the "Covered Major Medical Expenses" section of this Plan Document).

7.23 Charges for experimental procedures or drugs.

7.24 Charges for any services rendered by the claimant or by any person who is a relative by blood or marriage or resides in the same household as the claimant.

7.25 Charges in connection with an Illness or Injury that was deliberately self-inflicted, suicide or attempted suicide while sane or insane, (or attempted threat) or resulted from the person participating in an illegal act.

7.26 Charges in connection with an Illness or Injury that incurred or is a result of a declared act of war or military service.

7.27 Charges for drugs or vitamins that can be purchased without a doctor's prescription.

7.28 Charges in connection with experimental or obsolete procedures: the **Plan** will not pay for a Hospital stay for any procedure if it is no longer generally regarded as effective or if it is experimental in the sense that its effectiveness is not generally recognized.

7.29 Charges for treatment of obesity.

7.30 Charges for treatment of a sexual dysfunction not related to organic disease.

7.31 Charges for acupuncture.

7.32 Charges for radial keratotomy.

7.33 Charges in connection with temporomandibular joint disorders (TMJD).

7.34 Charges for care of corns, bunions (except capsular or bone surgery), calluses, nails of the feet, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, unless there has been continuous coverage under this Plan for two (2) years.

7.35 Charges for services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with custodial care

7.36 Additional charges for weekend admissions, when admission on a weekend was unnecessary.

7.37 Charges for elective abortion.

7.38 Charges for contraceptives regardless of intended use.

7.39 Charges in connection with intersex surgery (transsexual operation or complications therefrom).

7.40 Charges incurred while the Member is acting as a pilot or a member of a flight crew.

7.41 Charges for non-emergency care or treatment not incurred within the United States.

7.42 Charges for routine physical examinations, premarital examinations or routine immunizations.

7.43 Charges for organ transplants or any medical expenses incidental to hospitalization for an organ transplant.

7.44 Charges for personal or home-based artificial kidney equipment.

7.45 Charges for any expenses by surgery to the jaw (Maxilla or mandible) except to the extent necessary for the treatment of cancer or tumor, or to repair within one year, damage caused by a covered accident, and such repair occurs while covered under this Plan.

7.46 Charges for correction or treatment of congenital defects, except for treatment of a congenital abnormality in a covered Dependent born while the parent is covered for Dependant [sic] benefits under this Plan.

7.47 Charges for services rendered prior to the covered Person's effective date of coverage.

7.48 Charges for immunizations required for travel and physical exams for employment, vehicle licensing, or premarital purposes.

7.49 Charges for treatment of eating disorders, i.e., anorexia, bulimia.

ARTICLE 8.
PRE-ADMISSION CERTIFICATION (PAC) AND CONTINUED STAY REVIEW (CSR) REQUIREMENTS

8.1 Pre-Admission Certification ("PAC") and Continued Stay Review ("CSR") refer to the process used to certify the medical necessity and length of any Hospital confinement as a registered bed patient. PAC and CSR are performed by a specialized utilization review organization under contract with the **Plan.** PAC and CSR requirements apply to the Major Medical Benefits available under both Schedule II and Schedule III herein.

PAC should be requested by you or your dependent for each inpatient Hospital admission. You or your physician or the Hospital should call the review organization prior to each Hospital admission as a registered bed patient. To obtain the PAC or CSR organization in your area, contact Plan Administrator. Your physician will then be notified by the review organization of the length of certification for that admission. For emergency inpatient admissions, your physician or the Hospital should call the review organization directly for PAC.

When continued Hospital confinement past the number of days certified is indicated, you or the physician or Hospital should request CSR for the excess days, prior to the end of the certified length of stay.

NOTE: Failure to obtain mandatory pre-admission certification and continued stay review will result in reduced benefits.

All Hospital care must be certified prior to admission. Emergency admissions must be reported within 48 hours.

Benefits payable under this **Plan** for Hospital charges will be reduced for any charges made during a Hospital Confinement for which PAC is not performed.

Those expenses incurred for which payment is excluded because of failure to obtain PAC or CSR will not be considered as expenses incurred for the purpose of any other part of this **Plan,** except for the "Coordination of Benefits" section.

ARTICLE 9.
ELIGIBILITY

9.1 Employee Eligibility:

For non-occupational illness and injury benefits, an employee shall be eligible on the first day of the month for which his or her Employer pays its first contribution to the Trust and the employee is actively at work, or is mentally and physically able to work if not scheduled for work on such day. Eligibility for benefits is not effective until the employee has completed the enrollment process discussed in [sic] under "Enrollment" below.

9.2 Dependent Eligibility:

Dependents are eligible for benefits only through the Participant. Any dependent confined to a Hospital when that dependent would normally become eligible will first become eligible for benefits only after discharge from the Hospital. Newborn infant dependents are eligible if properly enrolled in the **Plan** and under a family membership. Refer to "Newborn Children" below.

Your eligible dependents are:

(A) Your legal spouse; and

(B) Your unmarried dependent children under age 19 (up to age 23) if a full-time student in an accredited college or university), including legally adopted children or stepchildren.

If a husband and wife are concurrently eligible under the **Plan** as employees, each dependent child of such husband and wife shall be considered a dependent of one spouse only.

No person shall be eligible for benefits as both an employee and a dependent. For dependents to be eligible, they must be mentally and physically able to engage in activities considered normal for persons of like age and sex.

9.3 Enrollment:

Enrollment is [sic] the **Plan** is the first step you must take to be able to receive benefits. For your own initial enrollment, complete the Enrollment Card distributed to you and return it to the Plan Administrator. To enroll new dependents in the **Plan** after your initial enrollment, complete and [sic] Enrollment Card and return it to the Plan Administrator within 30 days after marriage or 60 days prior to the birth or adoption of a child. If the Plan Administrator is not notified of change within 30 days after marriage or 60 days prior to the birth or adoption of a child, the child or spouse will be subject to the eligibility waiting periods for benefits (including pre-existing conditions limitations), unless there is a satisfactory explanation for an unavoidable delay in registering the child or spouse. Proof of marriage or a birth certificate may be required when you file for change in your family status.

Claims for benefits incurred prior to your enrollment card being received by the Plan Administrator, or for a dependent not listed on the card, may be denied unless there is a reasonable cause for not registering timely or not listing the dependent. Newborn children should be registered promptly.

ARTICLE 10.
TERMINATION OF BENEFITS

10.1 Coverage for Participants and their eligible dependents terminates on the date the Participant's covered employment terminates, whether by involuntary discharge, lay-off, transfer out of covered employment, or resignation. Coverage for Participants and their eligible dependents also terminates at the end of the month for which the last Employer contribution is paid. You should be aware that your coverage will terminate at the beginning of any month for which your Employer fails to pay the monthly contribution required by the **Plan** or other agreement.

All benefits end immediately if the **Plan** is terminated or if your employer ceases to be an Employer for purposes of the **Plan.**

ARTICLE 11.
MEDICARE PROVISIONS

11.1 All employee [sic] age 65 and over, who are eligible for coverage under this **Plan,** and the eligible spouse of any employee, if the spouse is age 65 or over, will be provided with benefits under this **Plan** unless such employee rejects the **Plan** and elects to treat Medicare as his/her only coverage.

If such employee elects to retain his/her coverage under this **Plan,** then the benefits of this **Plan** shall be determined before any benefits provided by Medicare. In the absence of any written election, this **Plan** will be primary.

Applicable to Medicare – Services Furnished to E.S.R.D. (End Stage Renal Disease) Beneficiaries Who are Covered Under Health Plans.

If a covered person becomes eligible for benefits under Medicare as a result of disability due to end stage renal disease and chooses to remain covered under this **Plan,** this **Plan** will pay its benefits first and Medicare will be the secondary payor for the first 18 months of disability. After the initial 18 months, Medicare will be the primary payor.

ARTICLE 12.
GENERAL PLAN EXCLUSIONS

12.1 In addition to the exclusions and limitations set forth in the various sections of this Plan Document, the following are circumstances which may cause loss of benefits and result in charges and expenses which are not payable by the **Plan.**

Benefits are denied when it is determined that, at the time the claim was incurred, you (or your dependent):

(A) Were not eligible for benefits claimed;

(B) Failed to submit required evidence to substantiate the claim;

(C) Failed to apply or make timely application for benefits;

(D) Made a material misstatement in connection with eligibility or the claim (the **Plan** shall have the right to recover from you any payments made in reliance on such misstatement); or

(E) Omitted facts or materials statements as to other insurance available to you or your dependents.

ARTICLE 13.
CLAIM PROCEDURES

13.1 Claiming Benefits:

Each claim for benefits must be made in writing on a form provided by the Plan Administrator. File your claim promptly. A late filing may cause loss of some benefits. Claims filed later than 90 days after treatment or Hospital confinement started, or services or supplies were received, may be denied, unless there is satisfactory explanation for unavoidable delay, but in no event will the **Plan** consider a claim filed more than one year after the treatment or Hospital confinement started.

13.2 Completing Claim Forms:

To expedite your claims, you should use the **Plan** claim form available from your Employer, or the Association. The forms and/or bills must contain the following information:

(A) Provider's federal tax identification number;

(B) Name of patient;

(C) Nature of Illness or Injury;

(D) Date and type of service rendered;

(E) Amount charges; and

(F) Amount paid by you or other insurance.

Drug claims must be on the **Plan's** claim form, and bills, not receipts, must be attached. The completed form must show the name of the drug prescribed ad [sic] Medically Necessary for the treatment. See the "Major Medical Benefits" section of this Plan Document for more information.

If more than one doctor is involved (such as an anesthesiologist, use two claim forms or use a claim form for the main doctor and submit the actual bill (not a copy) from the second doctor, person or organization making the charge.

Completed claim forms should be submitted to your Employer or the Plan Administrator.

13.3 Proof Of Loss:

Written proof of loss should be given to the Contract Administrator not later than 90 days after the date of such loss. If such proof is not given in the time allowed, the **Plan** will not reduce nor deny the claim for this reason, if it was not reasonably possible to do so. Proof must be given as soon as reasonably possible. In any event, except in the absence of legal capacity, proof required must be given no later than one year following the end of the 90 day period stated in this provision.

13.4 Payment of Claims:

Once a fully completed claim is submitted, the Plan Administrator will respond within ninety (90) days, with one of the following actions:

(A) Pay the claim;

(B) Send a written request for additional information;

(C) Send written notification of exclusion or denial of part, or all, of the claim; or

(D) Request, in writing, an additional ninety (90) days for further handling, and advise the claimant why the extra time is needed.

Subject to proof of loss, the Plan Administrator will determine if benefits are payable according to **Plan** provisions and administrative guidelines. Benefits will be paid or denied within 30 days upon receipt of due written proof, unless additional information is required to determine amounts payable.

Benefits will be paid to the employee whose injury or sickness, or whose dependent's injury or sickness is the basis of claim.

Benefits not in the form of periodic payments will be paid when the Plan Administrator receives written proof at the Administrator's office. Benefits in the form of periodic payments will be paid each week during the period for coverage. Any remaining balance will be paid at the end of the **Plan's** liability.

13.5 Facility Of Payment:

If, in the opinion of the Plan Administrator, an employee is not capable of giving a valid receipt; and there is no written evidence of the appointment of a guardian, the **Plan** may make payments to the person or institution providing his care and support.

If an employee dies with benefits due him, the **Plan** will pay them to his estate. The **Plan** may, at the option of the Employer, pay all or part of them to:

(A) His spouse, if living; otherwise

(B) The employee's living children equally; otherwise

(C) The employee's living parents equally.

Any payment made under this section will fully discharge the **Plan** to the extent of the payment.

Subject to written direction of the covered person in any application or otherwise, all or a portion of any benefits provided by the **Plan** on account of hospital, nursing, medical, or surgical service may, at the **Plan's** option, and unless the covered person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the services be rendered by a particular hospital or person.

Any payment made by the **Plan** in accordance with this section will fully discharge the **Plan's** liability to the extent of such payment.

At the option of the Plan Administrator, payments may be made directly to providers of service when, in the Plan Administrator's opinion, an Assignment of Benefits may exist.

13.6 Recovery Of Payments:

The **Plan** reserves the right to deduct from future payments the amount of any prior payment which was:

(A) Made in error;

(B) Made to an ineligible person;

(C) Found to be due to occupational illness or accident; or

(D) Made due to a misstatement:

(1) In the claim form; or

(2) In an application for coverage within 2 years after coverage started.

The deduction will be made from future payments, to the covered person, or to any member of the covered person's family.

13.7 Assignment Of Benefits:

A covered employee may authorize the **Plan** to pay benefits for expenses due to medical care and treatment directly to the provider on whose charges claim is based. The **Plan** will not be responsible for the validity of any assignment. Satisfactory proof of assignment must be given to the Administrator before payment will be made to an assignee. The **Plan** wili be discharged from all liability to the extent of any payment made with such authorization or before such authorization is received. The service need not be rendered by a particular provider.

13.8 Claim Denial:

In the event a claim is denied, the covered person will be advised of the following:

(A) The reason for the denial;

(B) The **Plan** provisions on which the denial was based;

(C) Any additional material or information needed for further review of this claim;

(D) An explanation of the Plan's review procedures.

If the claim is denied, the covered person may appeal the denial by submitting a written request for review to the Claims Adjuster within 60 days of receipt of notification of the denial. The covered person has the right to (1) see the **Plan** document and other papers affecting the claim, (2) argue against the denial in writing, and (3) have a representative act on his behalf in the appeal.

The Plan Administrator shall have final authority to determine all appeals. The Plan Administrator shall have final authority to interpret the **Plan** and ascertain all facts relating to appeals. Final decisions on the appeal shall be in writing and shall be made within a sixty (60) day period if the next Benefit Review Committee meeting does not take place within the first sixty (60) day period. If a final decision will not be rendered within the first sixty (60) day period, you will be so advised in writing.

If the appeal is denied, the final decision shall include specific reasons for the denial, be written in a manner calculated to be understood by the Participant, and contain specific reference to the pertinent **Plan** provisions upon which the decision was based.

13.9 Appeal Procedure:

(A) A covered employee or his duly authorized representative has a right to appeal denial of a claim to the Contract Administrator. The request for review shall be made in writing.

(B) Written application for review of denial of a claim must be received in the office of the Contract Administrator not later than 60 days following receipt by the claimant of the denial of his claim, or no appeal will be allowed.

(C) The Contract Administrator shall decide the appeal within 60 days after receipt of the appeal, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but in no event more than 120 days.

(D) The decision on review shall be in writing, specify the reason for the decision, and make specific reference to the pertinent **Plan** provisions upon which the decision is based.

(E) All written decisions, by the Contract Administrator or Employer, shall, to the extent possible, be written in a manner calculated to be understood by the claimant.

(F) Any final determination of a claim by the Contract Administrator may be appealed to the Employer by filing written notice of appeal to the Employer with the Contract Administrator. The Employer shall take up any appeal of a final claim determination by the Contract Administrator at its next meeting following written notice of appeal being filed with the Contract Administrator. Written notice of the Employer's determination relative to any appeal shall be mailed to the affected parties by the Contract Administrator within 10 days of the date of such determination. Any claim determination of the Contract Administrator or any appeal by the Employer is subject to arbitration as hereinafter provided.

13.10 Right to Physical Examination and Autopsy:

A physician designed by the Plan Administrator will have the right and opportunity to examine, at its expense,

any person whose Illness or Injury is the basis of any claim, when and as often as reasonably required, and, in the event of death, to make an autopsy unless prohibited by law.

13.11 Legal Action:

No legal action can be started:

(A) Within 60 days after the claim form or proof is furnished to the Contract Administrator; or

(B) More than three years after the claim form or proof is due.

If any time set out in this section is less than allowed by the state in which an employee lives when he becomes covered, it is extended to the time required.

ARTICLE 14.
COORDINATION OF BENEFITS (COB)

NOTE! THIS ARTICLE IS NOT APPLICABLE TO OCCUPATIONAL INJURY AND ILLNESS BENEFITS AVAILABLE UNDER THIS PLAN.

14.1 This Plan is not insurance, and is not an additional payment plan. It is strictly and only a reimbursement plan. So that the Participants will understand, this Plan has been adopted for the protection of the Participants to make certain that they will be made whole for their out-of-pocket expenses, to the extent possible, for medical and hospital care for non-occupational illness and injury.

If you have any other source of payment, this Plan will pay the difference, if any, up to the maximum amount of payments as provided herein.

(A) You first are required to make application for benefits under any such plan or any other source other than this **Plan**.

(B) You must make full disclosure of all benefits that you are entitled to received [sic] from another plan or course in your claim for benefits under this **Plan**.

(C) In the event that you fail to disclose any other source of plan payment, the claim shall be considered a fraudulent claim for benefits and you may be disqualified from receiving any benefits under this **Plan**.

The following is an example of the requirement concerning "any other source of payment." If your spouse (husband or wife) is an eligible dependent under this **Plan**, he or she normally would be covered. But if you spouse works and is covered at his or her job by any sort of benefit plan or insurance which could also cover you and your dependents, you must first seek payment from that source. Also included in any other sources is governmental programs. This also applies to the employee Member who is the claimant.

Benefits under any other plan means any other coverage you may be entitled to regardless of the source. In other words, where there is an opportunity to receive money from another source, you are not entitled to any benefits under this **Plan** except for the difference in charges and payments by the other plan or source, if any, as provided herein.

For purposes of this Article, the term "plan" includes any individual or group, or any contract providing benefits or services for Hospital, surgical, medical, dental,

prescription drugs and optical care. If the other plan is also self-insured and has a non-duplication feature that conflicts with this **Plan**, then the plan which covers the claimant as an employee (or named insured) pays as though no other plan existed; remaining Recognized Charges are paid under a plan which covers the claimant as a dependent. If the claimant is a dependent child covered under the plans of both parents, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday (only the month and day are considered), the plan which covered the parent no longer shall be primary.

ARTICLE 15.
SUBROGATION

15.1 If you or a dependent brings an action against a third party for personal injuries, you (or your dependent) are required to execute an assignment to the **Plan** of the interest in that action to the extent of the amount of benefits paid by the **Plan**. This assignment is required so that the **Plan** can recover any benefit payments advanced on your behalf. This assignment must be made before benefit payments are allowed from the **Plan**. This Section is applicable to states with no fault auto laws.

ARTICLE 16.
RIGHT TO RECOVERY

16.1 If any payment is made due to false statement or error, the **Plan** shall have the right to recover such amount directly from the Participant. The amount of such payment may be deducted from any future benefits payable on behalf of the Participant or his dependents.

ARTICLE 17.
CONTINUATION OF COVERAGE (COBRA)

17.1 Description of Continuation Benefits:

Under the requirements of COBRA, an employer must offer to continue group health benefits to certain Participants and dependents. A person who would otherwise lose coverage as a result of a "qualifying event" is entitled to elect continuation coverage. COBRA coverage available under this **Plan** will be the same as the coverage provided a similarly situated covered person unaffected by a qualifying event. Continuation coverage may be obtained only on a self-pay basis.

The **Plan** shall offer and furnish COBRA continuation coverage only to the extent required by law, and shall not assume the COBRA obligation of employers except where expressly provided herein or as required by law. COBRA beneficiaries are eligible for coverage hereunder only for so long as the employer with respect to which they are qualified beneficiary remains a contributing employer. In the event any contributing employer terminates its participating in the **Plan**, the employer shall assume all COBRA responsibility for qualified beneficiaries who are eligible for COBRA coverage.

17.2 Qualifying Events:

A "qualifying event" includes any of the following that result in a loss of **Plan** coverage:

(A) For an employee, termination of employment (other than for gross misconduct) or reduction of hours worked so as to render the employee ineligible for coverage;

(B) For a spouse and eligible dependents, death of the employee;

(C) For a spouse, divorce or legal separation;

(D) For dependent child, ceasing to qualify as a dependent under the **Plan**;

(E) For a spouse and eligible dependents, the employee's entitlement to Medicare benefits; or

(F) For retired employees receiving retiree health benefits, loss of retiree coverage due to an employer bankruptcy.

17.3 Applicable Premium Requirements:

Self-contributions shall be made by eligible persons who have elected continuation coverage in a manner and form prescribed by the Benefit Review Committee. The Participant or dependent electing COBRA continuation coverage shall be required to pay any applicable premium for the continuation coverage and has the option to make these payments in monthly installments. The Benefit Review Committee shall determine the premium annually, in accordance with costs of the **Plan's** risk and demographics. If the covered employee or dependent elects continuation coverage during the 45 day qualifying event, then he or she will be permitted continued coverage by monthly payments to the **Plan** in accordance with all other provisions. All applicable premiums must be paid in the manner required by the Benefit Review Committee.

17.4 Employer Notification Requirements:

An Employer must notify the Plan Administrator of the following qualifying events:

(A) Death of the participating employee;

(B) Termination or reduction in hours of participating employee; and

(C) Filing by the Employer of any petition in bankruptcy.

The Employer must furnish the Plan Administrator with such notice within 30 days of the qualifying event.

17.5 Covered Person's Notification Requirements:

(A) Divorce or legal separation of the Participant from his spouse;

(B) A dependent child ceasing to qualify as a dependent under the generally applicable terms of the **Plan**;

(C) The employee's eligibility for Medicare; and

(D) Certification of disability from Social Security Administration.

17.6 Covered Person's Election Obligation:

Continued coverage is not automatic. Coverage must be elected within 60 days of the latest of the following:

(A) The qualifying event; or

(B) The date the employee or dependent is advised by the Plan Administrator of the right to elect continued coverage.

Notice of the right to elect continuation coverage to a covered employee or spouse will be deemed notice to any dependent child residing with that person. If the covered employee does not elect to continue coverage, the spouse and dependents may separately elect continuation coverage. If there is a choice among types of coverage under

the **Plan**, each qualified beneficiary is entitled to make a separate election among types of coverage.

17.7 Length of Continuation Coverage and Termination of Coverage:

If elected, the maximum coverage period for continuation coverage for a qualifying event involving termination of employment or reduced working hours is 18 months from the date of the qualifying event. Totally disabled COBRA Participants may continue for 29 months. With respect to retired employees eligible for COBRA on account of their employer's bankruptcy petition, coverage shall end on the date of the death of the qualified beneficiary, or in the case of the surviving spouse or dependent children of the covered employee, the date which is 36 months after the date of the employee's death.

For all other qualifying events, the maximum period is 36 months from the date of the qualifying event. The maximum coverage period begins with the date of the qualifying event, and not the date on which coverage is lost by virtue of the qualifying event, except where otherwise provided by rules adopted by the Trustees. In addition, if any employee becomes eligible for Medicare (whether or not such eligibility constitutes a qualifying event, e.g., if the employee becomes eligible for Medicare after the qualifying event and during the COBRA eligibility period), the period of coverage for qualified beneficiaries other than the employee for such event or any subsequent qualifying event shall be 35 months from the

date of Medicare eligibility. Other events will cause coverage to end sooner and this termination of coverage will occur on the earliest of any of the following:

(A) The date the employee's employer ceases to provide any group health plan to any employee (where an employer withdraws from this **Plan**, COBRA benefits shall be provided by the employer under the employer's separate plan, rather than this **Plan**);

(B) The date of the employee or dependent fails to pay any required contribution or other payment;

(C) The date the employee or dependent becomes covered under any other group health plan which does not contain an exclusion or limitation with respect to pre-existing conditions of the beneficiary;

(D) The date a divorced or widowed spouse remarries and becomes covered under another group health plan;

(E) The date the beneficiary becomes entitled to Medicate benefits; or

(F) The date the beneficiary becomes disqualified for cause under the terms of the **Plan**.

17.8 Multiple Qualifying Events:

Generally, the maximum coverage period cannot be expanded. There is an exception to this general rule, however, with respect to a qualifying event, such as termination of employment, that gives rise to an 18-month maximum coverage period. If, during such an 18-month period, a second qualifying event (e.g., death or divorce) occurs, the COBRA eligibility is expanded to a total of 36

months for those individuals who (a) were qualified beneficiaries when the first qualifying event occurred, and (b) remained covered under the **Plan** when the second qualifying event occurred.

17.9 Extension of Continuation Coverage for Disabled Beneficiaries:

An employee or dependent who is eligible for 18 months COBRA coverage (on account of the termination of employment or reduction in hours) shall be eligible for an additional 11 months coverage, provided the beneficiary is disabled (within the meaning of Social Security Act) at the time of the qualifying event. In order to qualify for this additional 11 months COBRA eligibility, the qualifying beneficiary must notify the Employer of the Social Security determination within 60 days of such determination. The extended period of continuation coverage shall expire before 29 months if a final determination is made that the Beneficiary is no longer disabled (within the meaning of the Social Security Act). In such event, the continued coverage shall end on the first day of the month that begins more than 30 days after the date of such final determination. The employee or dependent must notify the Employer within thirty days after the final determination is made. The Benefit Review Committee may increase the applicable premium for this additional 11 month period in accordance with applicable law.

ARTICLE 18.
OCCUPATIONAL INJURY AND ILLNESS BENEFITS
EMPLOYMENT-RELATED DISABILITY BENEFITS

NOTICE! Your employer has elected to provide benefits for injuries and illness resulting from occupational activity under the Employee Welfare Benefit Plan. By making this election, your employer has elected to provide occupational injury and illness benefits at levels commensurate with the workers' compensation laws of the states in which your employer has employees. Notice is hereby given of the election by your employer to provide for injuries resulting from occupational activity under the **Plan**.

NOTICE! The following provisions apply *only* to the Occupational Injury and Illness Benefits and Employment-Related Disability Benefits portion of the **Plan**. To the extent that the provisions in this section conflict with any other provisions contained in this Plan Document, the provisions in this section shall control.

18.1 Eligibility:

With respect to the Occupational Injury and Illness Benefits and Employment-Related Disability Benefits available under the **Plan**, all employees are eligible upon their employment, with the effective date of coverage being the date of employment.

18.2 Occupational Injury and Illness Benefits:

Medical Benefits: All reasonable charges relating to occupational injury or occupational illness, up to the same level as specified in the schedule of benefits in the applicable workers' compensation statute;

18.3 Occupational Injury and Illness defined:

(A) For purposes of this **Plan**, the term "occupational injury" shall mean damage or harm to the physical structure of the body and those diseases or infections naturally resulting from the damage or harm, arising out of and in the course and scope of the employee's employment with the employer.

(B) For purposes of this **Plan**, the term "occupational illness" shall mean a disease arising out of and in the course of an employee's employment with the employer that causes damage or harm to the physical structure of the body. The term does not include an ordinary disease of life to which the general public is exposed outside of employment.

18.4 Employment-Related Disability Benefits:

The **Plan** provides employees with a weekly benefit payment while absent from work due to occupational injury or illness. The plan pays time lost compensation from the first hour of such occupational injury or illness.

(A) Employment-Related Disability Benefits are available to any employee after being absent from work because of orders from a doctor;

(B) The Employment-Related Disability Benefits available under the **Plan** are equal to or exceed the level as specified in the applicable workers' compensation statute, and are payable from the first day of disability.

18.5 Exceptions and Limitations:

With respect to all Occupational Injury and Illness Benefits and Employment-Related Disability Benefits

available under the **Plan**, no payment will be made for claims resulting from:

(A) Suicide or any attempt thereof by the employee, while sane or self destruction or any attempt thereof by the employee while sane;

(B) Infections except pyogenic infections caused wholly by an injury for which benefits are available under the **Plan**;

(C) War or any act of war, or accident occurring while the employee is in the military, naval or air service of any country;

(D) Accident occurring while the employee is operating, or learning to operate, or performing duties as a member of the crew of any aircraft;

(E) Dental treatment, except as a result of injury to sound natural teeth;

(F) Replacement of eyeglasses or eye examinations for the correction of vision or fitting of glasses unless an injury has caused impairment of sight;

(G) Participating in team sports or other athletic activities;

(H) The employee's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician;

(I) Injuries caused by the employee's wilful intention and attempt to injure himself/herself or to unlawfully injure another person;

(J) Injuries arising out of an act of a third person intended to injure the employee because of personal reasons and not directed at the

employee as an employee or because of the employment;

(K) Injuries arising out of voluntary participation in an off-duty recreational, social, or athletic activity not constituting part of the employee's work-related duties;

(L) Injuries arising out of an act of God, unless the employment exposes the employee to a greater risk of injury from an act of God than ordinarily applies to the general public.

(M) Taking part in a strike, civil disorder, or riot;

(N) Taking part in police, fire fighting, or other emergency services; or

(O) Committing or attempting to commit a crime.

18.6 Claims Payment Provisions:

(A) Notice and Proof of Loss:

With regards to claims for Occupational Injuries or Illness, an employee must submit written notice of the employee's claim to the Plan Administrator within five (5) days after the commencement of such claim, on a claim form approved by the Plan Administrator.

(B) Payment of Benefits:

All claim payments will be sent to the employee or to the employee's doctor or other benefit provider, if the employee's claim has been assigned. If the employee dies before all benefits have been paid, the remaining benefits may be paid to any relative of the employee or to any person or corporation appearing to the Plan

Administrator to be entitled to payment. The **Plan** shall fully discharge its liability by such payments.

18.7 Arbitration:

Should an irreconcilable difference of opinion arise between the Plan Administrator and a claimant as respects [sic] any claim arising under the **Plan**, such difference shall be submitted to arbitration upon written request of either the Plan Administrator or claimant. The procedure for such arbitration shall be as outlined under the General Provisions herein.

ARTICLE 19.
EMPLOYMENT-RELATED ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

19.1 Benefit Conditions:

Benefits will be paid if a covered employee incurs any of the losses listed below while covered only if:

(A) The loss is due to an injury which occurred while the employee was covered;

(B) The loss occurs no more than 90 days after the injury; and

(C) The Contract Administrator receives proper proof of the loss.

Benefits for loss of life will be paid to the employees beneficiary, as explained in Death Benefits For Employees. Benefits for other losses will be paid to the employee.

19.2 Level of Benefits:

Benefits for on the job injuries resulting in death or bodily dismemberment shall be equal to or exceed those benefits available under applicable worker's compensation law. The full amount of benefit will be paid only once for any one accident, no matter how many of the losses described above occur as a result of that accident.

19.3 Exceptions and Limitations:

With respect to all Occupational Injury and Illness Benefits and Employment-Related Disability Benefits available under the **Plan**, no payment will be made for claims resulting from:

(A) Suicide or any attempt thereof by the employee, while sane or self destruction or any attempt thereof by the employee while sane;

(B) Infections except pyogenic infections caused wholly by an injury for which benefits are available under the **Plan**;

(C) War or any act of war, or accident occurring while the employee is in the military, naval or air service of any country;

(D) Accident occurring while the employee is operating, or learning to operate, or performing duties as a member of the crew of any aircraft;

(E) Dental treatment, except as a result of injury to sound natural teeth;

(F) Replacement of eyeglasses or eye examinations for the correction of vision or fitting of glasses unless an injury has caused impairment of sight;

(G) Participating in team sports or other athletic activities;

(H) The employee's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician;

(I) Injuries caused by the employee's wilful intention and attempt to injure himself/herself or to unlawfully injure another person;

(J) Injuries arising out of an act of a third person intended to injure the employee because of personal reasons and not directed at the employee as an employee or because of the employment;

(K) Injuries arising out of voluntary participation in an off-duty recreational, social, or athletic activity not constituting part of the employee's work-related duties;

(L) Injuries arising out of an act of God, unless the employment exposes the employee to a greater risk of injury from an act of God than ordinarily applies to the general public.

(M) Taking part in a strike, civil disorder, or riot;

(N) Taking part in police, fire fighting, or other emergency services; or

(O) Committing or attempting to commit a crime.

19.4 Claims Payment Provisions:

(A) Notice and Proof of Loss:

With regards to claims for Occupational Injuries or Illness, an employee must submit written

notice of the employee's claim to the Plan Administrator within five (5) days after the commencement of such claim, on a claim form approved by the Plan Administrator.

(B) Payment of Benefits:

All claim payments will be sent to the employee or to the employee's doctor or other benefit provider, if the employee's claim has been assigned. If the employee dies before all benefits have been paid, the remaining benefits may be paid to any relative of the employee or to any person or corporation appearing to the Plan Administrator to be entitled to payment. The **Plan** shall fully discharge its liability by such payments.

19.5 Arbitration:

Should an irreconcilable difference of opinion arise between the Plan Administrator and a claimant as respects any claim arising under the **Plan**, such difference shall be submitted to arbitration upon written request of either the Plan Administrator or claimant. The procedure for such arbitration shall be as outlined under the General Provisions herein.

ARTICLE 20.
OPTIONAL DENTAL CARE BENEFITS

Notice! The provision under this Article apply to the Optional Dental Care Benefits available under the Plan. Employees and their dependents are eligible for the Optional Dental Care Benefits only if they are covered for Major Medical Benefits under Schedule III hereunder, make application and are approved for such

benefits, and pay to the Plan Administrator contributions for such benefits. All benefits available under this Addendum "A" are not to be considered Eligible Charges for purposes of satisfying the Deductible applicable to Hospital-Surgical Benefits under the Plan.

20.1 Schedule of Dental Care Benefits:

Annual Deductible:

$50.00 Individual;
$150.00 Family (3 Individuals)

Annual Benefit Maximum

$1,500.00 per Individual per year

Lifetime Orthodontic[1] Maximum

$1,200.00 Individual

The following chart summarizes amounts paid by the Plan.

Benefit Description: Subject	Plan pays to Deductible		Additional Limitations and Exclusions
Preventative Services	No	100%	Subject to annual benefit maximum
Basic Services	Yes	80%	Subject to annual benefit maximum
Major Services	Yes	50%	Subject to annual benefit maximum

[1] Orthodontic Services are available only for dependents up to age 19.

Orthodontic Services[1]	Yes	50%	Subject to annual benefit maximum and Lifetime Orthodontic Maximum

20.2 About your Dental Care Benefits:

All benefits under this Plan must satisfy some basic conditions. The following conditions are commonly included in dental benefit plans but are often overlooked or misunderstood.

(A) Alternate Procedure: The Plan provides benefits only for the most cost-effective treatment of a dental condition which provides a professionally acceptable result as determined by national standards of dental practice.

(B) Pre-Treatment Review: The Plan provides benefits for treatment estimated to be over $500 only when your dentist submits a proposed course of treatment prior to the actual performance of services. Evaluation of the treatment is subject to alternate procedure and does not guarantee payment of benefits when the actual services are performed.

(C) Usual, Customary and Reasonable Charges: The Plan provides benefits only for covered expenses that are equal to or less than the usual, customary and reasonable charge in the geographic area where services or supplies are provided. Any amount that exceeds the

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[1] Orthodontic Services are available only for dependents up to age 19.

usual, customary and reasonable charge is not recognized by the Plan for any purpose.

(D) Dental Care Providers: The Plan provides benefits only for covered services rendered by a dentist or dental hygienist as those terms are specifically defined in the Definitions section.

(E) Benefit Year: The word "year", as used in this Plan, refers to the benefit year which is the 12-month period beginning January 1 and ending December 31. All benefit maximums and deductibles accumulate during the benefit year.

(F) Pre-Existing Clause: No Benefits will be paid for Eligible Expenses incurred by late entrants before 12 consecutive months of participation in this Plan; or for Expenses for services performed after the date of coverage ends under this Plan.

20.3 Definitions:

As used in this Article, the following terms shall have the definitions as described herein.

(A) Accident: An unforeseen and avoidable event resulting in an injury which is not due to any fault of the covered person.

(B) Active Course of Orthodontic Treatment: The period which begins when the first orthodontic appliance is installed and ends when the last active appliance is removed.

(C) Dental Alternate Procedure: The most cost-effective treatment of a dental condition which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the

current clinical oral condition based upon the diagnostic material submitted by the dentist.

(D) Calendar Year: The 12-month period beginning on January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the calendar year.

(E) Dental Care Provider: A dentist, dental hygienist, physician or nurse as those terms are specifically defined in this section.

(F) Dental Hygienist: A person trained and licensed to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed dentist.

(G) Dentist: A person acting within the scope of his/her license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state of jurisdiction where the services are rendered.

(H) Dental Expenses Incurred: The date a dental service or treatment is performed, except for the following services or treatments:

(1) Dentures or bridgework – the date the impressions were taken.
(2) Crowns, inlays, onlays – the date the teeth are first prepared.
(3) Root canal therapy – the date the pulp chamber is opened.
(4) Active orthodontic care – the date the appliances are inserted.

(I) General Anesthesia: An agent introduced into the body which produces a condition of loss of consciousness.

(J) Pre-Treatment Review: A proposed course of treatment estimated to be over $500.00 must be submitted by your dentist for review prior to the actual performance of services. Evaluation of the course of treatment is subject to alternate procedures and does not guarantee payment of benefits when the actual services are performed.

20.4 Deductibles:

A deductible is the amount of covered expenses you must pay during each year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When three (3) family members meet their individual deductibles, the family deductible is satisfied and no further deductible will be applied for any covered family member during the remainder of that year.

The annual individual and family deductible amounts are shown on the Schedule of Dental Care Benefits.

(A) Deductible Carry-over: A deductible carry-over is the amount of covered expenses accumulated toward the individual deductible during the last three (3) months of a year that may also apply toward the deductible for the next year.

(B) Common Accident Deductible: When two (2) or more persons in your family are injured in the same accident only one deductible must be met before the Plan will consider benefits for expenses incurred as a result of the accident.

20.5 Co-Payments:

Co-payment percentages represent the portions of covered expenses paid by you and by the Plan after the satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed usual, customary and reasonable charges for covered expenses.

The co-payment percentages are shown on the Schedule of Dental Care Benefits.

20.6 Benefit Maximums:

Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum also applies to a specific time period, such as annual or lifetime. Whenever the word "lifetime" appears in this Plan in reference to benefit maximums, it refers to the period of time you or your dependents participate in this Plan

The benefit maximums applicable to this Plan are shown in the Schedule of Dental Care Benefits.

20.7 Covered Preventative Expenses:

The Plan will provide benefits as outlined on the Schedule of Dental Care Benefits for expenses considered preventative services according to all provisions, requirements and limitations of the Plan.

.(A) Oral examination including prophylaxis (cleaning of the teeth), limited to once in a period of 6 months.

(B) Bite-wing x-rays, limited to once in a period of 6 months.

(C) Full mouth x-rays, limited to once every three (3) years.

(D) Topical application of sodium or stannous fluoride for children under age 19, limited to once a year.

(E) Space maintainers.

20.8 Covered Basic Expenses:

The Plan will provide benefits as outlined on the Schedule of Dental Care Benefits for expenses considered basic services according to all provisions, requirements and limitations of the Plan.

(A) Examination in connection with emergency palliative treatment.

(B) Examination for consultation purposes.

(C) Injections of antibiotic drugs by the attending dentist

(D) Tooth extractions.

(E) Oral Surgery, including surgical extractions.

(F) Administration of general anesthesia and/or intravenous sedation in connection with oral surgery.

(G) Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed teeth.

(H) Study models.

(I) Treatment of periodontal and other diseases of the gums and supporting structures of the mouth.

(J) Endodontic treatment.

20.9 Covered Major Expenses:

The Plan will provide benefits as outlined on the Schedule of Dental Care Benefits for expenses considered major services according to all provisions, requirements and limitations of the Plan.

(A) Gold restorations, only when due to decay or traumatic injury.

(B) Installation of crowns, bridges, or partials.

(C) Installation of dentures.

(D) Inlays, onlays and crowns, only when due to decay or traumatic injury.

(E) Repair or recementing of crowns, inlays or onlays.

(F) Adjusting, relining or rebasing of dentures after they have been installed for more than six (6) months.

(G) Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth which were extracted while covered under this Plan.

(H) Replacement of an existing partial or full removable denture or fixed bridgework; the addition of teeth to an existing partial or removable denture; or, bridgework to replace teeth which were extracted if satisfactory evidence is presented to the Plan that:

(1) The addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed and while a Participant in the Plan.

(2) The existing denture or bridgework cannot be made service-able and was installed at least five (5) years prior to the replacement date.

(3) The existing denture is an immediate temporary denture replacing one or more natural teeth extracted while participating in this Plan, replacement by a permanent denture is required, and the replacement takes place within twelve (12) months from the placement of the temporary denture.

(I) Precision or semi-precision attachments for prosthetic devices.

(J) Periodontal appliances.

(K) Occlusal adjustment, except in connection with periosurgery.

20.10 Covered Orthodontic Expenses:

The Plan will provide benefits, as outlined on the Schedule of Dental Care Benefits, for expenses related to the following orthodontic services according to all provisions, requirements and limitations of the Plan for your dependents up to age 19.

(A) Correction of an extreme buccolingual version of the teeth, either unilateral or bilateral (the teeth are pushed out toward the cheek or in toward the tongue on one or both sides.)

(B) Correction of a protrusion of the upper teeth of more than three (3) millimeters.

(C) Correction of a protrusion or retrusive relation of the maxillary or mandibular arch of at least 1 cusp (the upper and lower teeth buck back).

(D) Correction of an arch length difference of more than three (3) millimeters in either the maxillary or mandibular arch.

(E) Correction of a bimaxillary protrusion of three (3) millimeters or more.

(F) Correction of a cross-bite.

(G) Necessary services related to an active course of orthodontic treatment, including but not limited to tooth extractions and x-rays.

(H) Adjustment of active orthodontic appliances.

(I) Harmful habit appliances.

20.11 Dental Expenses Not Covered:

The Plan will not provide benefits for any of the items listed in this section. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. There may be expenses in addition to those listed below which are not covered by the Plan.

(A) Services rendered by anyone other than a covered dental care provider.

(B) Any portion of a charge which exceeds the usual, customary and reasonable charge for the geographic area in which services are rendered.

(C) Any service, supply or treatment which does not meet the standards accepted by the American Dental Association (ADA).

(D) Services or supplies for which there is no legal obligation to pay, or charges which would not be made except for the availability of benefits under this Plan.

(E) Services furnished by or for the U.S. government or any other government, unless payment is legally required.

(F) Any condition, disability, or expense sustained as a result of being engaged in an illegal occupation, commission or attempted commission of an assault or other illegal act, intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime, participation in a civil revolution or a riot, duty as a member of the armed forces of any state or country or a war or act of war which is declared or undeclared.

(G) Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under the Workers' Compensation Act or similar legislation.

(H) Services or supplies which are primarily cosmetic or experimental in nature.

(I) Expenses for preparing dental reports, itemized bills or claim forms.

(J) Mailing and/or shipping and handling charges.

(K) Charges for broken appointments or telephone calls.

(L) Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces or a government.

(M) Intentional self-inflicted injury or illness while sane or insane.

(N) Travel expenses of a physician or covered person.

(O) Professional services performed by a person who ordinarily resides in your household or who is related to the covered person, such as a spouse, parent, child, brother, sister, or in-law.

(P) Any service received from a Health Maintenance Organization (HMO) if the individual is a Participant in the HMO.

(Q) Treatment or services rendered outside the United States of America or its territories except for the treatment of an accidental injury or a medical emergency.

(R) Expenses used to satisfy Plan deductibles.

(S) Expenses eligible for consideration under any other Plan of your employer.

(T) Expenses incurred for services rendered prior to the date of coverage under this Plan.

(U) Training, educational instruction or materials relating to dietary counseling, personal oral hygiene or dental plaque control.

(V) Dentures and/or bridgework (including crowns and inlays forming abutments) when the charges are incurred for teeth extracted prior to the effective date of coverage under this Plan.

(W) Prescription drugs.

(X) The replacement of a lost, stolen or missing prosthetic device.

(Y) Services and supplies for personalization or characterization of prosthetic devices.

(Z) Orthodontic services and/or treatment, except as specified in the Covered Dental Expenses section.

(AA) Procedures and appliances to increase vertical dimension or restore occlusion.

(AB) Sealants.

(AC) Tooth implants.

(AD) Myofunctional therapy.

(AE) Athletic mouth guards.

(AF) Duplicate prosthetic devices or appliances.

(AG) Treatment, by any means, of jaw joint problems including temporomandibular joint dysfunction syndrome (TMJ) and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint.

(AH) Treatment of a fractured or dislocated jaw.

(AI) Services related to any active course of orthodontic treatment which began prior to the date of coverage under this Plan.

(AJ) Periodontal splinting.

(AK) Veneers.

(AL) Eligible expenses incurred by late entrants before 12 consecutive months of participation in this Plan, and for expenses for services performed after the date coverage ends under this Plan.

ARTICLE 21.
OPTIONAL VISION CARE BENEFITS

Notice! The provisions under this Article apply to the Optional Vision Care Benefits available under the Plan. Employees and their Dependents are eligible for the Optional Vision Care Benefits only if they are covered for Major Medical Benefits under Schedule III hereunder, make application and are approved for such benefits and pay to the Plan Administrator contributions for such benefits. All benefits available under this Addendum "B" are not to be considered Eligible Charges for purposes of satisfying the Deductible applicable to Hospital-Surgical Benefits under the Plan.

21.1 Schedule of Vision Care Benefits:

The following summarizes amounts paid by the Plan.

Benefit Description:	Plan pays:	You Pay:	Additional Limitations and Explanations:
Examination	$35	Any amount in excess of Plan payment	Limited to 1 exam every 12 consecutive months
Lenses: Single Bi-Focal Tri-Focal Lenticular	 $35 $50 $75 $128	Any amount in excess of Plan payment	Limited to 1 pair of lenses every 12 consecutive months if medically necessary
Frames	$35	Any amount in excess of Plan payment	Limited to 1 pair every 12 consecutive months
Contacts: Non-cosmetic Cosmetic	 $350 $100	Any amount in excess of Plan payment	Limited to 1 pair of lenses every 12 consecutive months if medically necessary
Tints: Single Bi-Focal Tri-Focal	 $15 $25 $25	Any amount in excess of Plan payment	
Tonometry	$6	Any amount in excess of Plan payment	
Biomicroscopy	$6	Any amount in excess of Plan payment	
Visual Fields Study	$6	Any amount in excess of Plan payment	

21.2 Covered Vision Benefits:

When all of the provisions of this Plan are satisfied, the Plan will provide, or make available, the benefits as outlined on the Reference Chart of Vision Benefits only for the services and supplies listed in this Article.

(A) Vision examinations by a physician which include case history, visual acuity (clearness of vision), external examination and measurement, interior examination with ophthalmoscope; pupillary reflexes and eye movements; retinoscopy (shadow test); subjective refraction; coordination measures (far and near); medicating agents for diagnostic purposes; and, analysis of findings with recommendations and prescription if required.

(B) Tonometry (glaucoma test) in connection with a vision examination.

(C) Glass or plastic lenses prescribed by a physician. A gradient tint equal to Tints #1 or #2 may be added to the lenses.

(D) One (1) pair of frames to hold prescribed lenses.

(E) One (1) pair of contact lenses as an alternative to conventional lenses.

(F) One (1) pair of contact lenses instead of conventional lenses when covered person is being treated by a physician for a condition such as anisometropia, heratoconus, following cataract surgery or to correct extreme visual acuity problems that cannot be corrected with conventional lenses.

21.3 Vision Expenses Not covered:

The Plan will not provide benefits for any of the items listed in this section. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. There may be expenses in addition to those listed below which are not covered by the Plan.

(A) Services received more frequently than as outlined on the Reference Chart of Vision Benefits.

(B) Services in excess of the maximums as stated on the Reference Chart of Vision Benefits.

(C) Services or supplies for which there is no legal obligation to pay, or expenses which would not be made except for the availability of benefits under this Plan.

(D) Services furnished by or for the U.S. government or any other government unless payment is legally required.

(E) Training or educational instruction and materials.

(F) Expenses for preparing medical reports, itemized bills, or claim forms.

(G) Mailing and/or shipping and handling expenses.

(H) Expenses for broken appointments or telephone calls.

(I) Professional services performed by a person who ordinarily resides in your household or who is related to the covered person such as a spouse, parent, child, brother, sister or in-law.

(J) Experimental equipment, services or supplies which have not been approved by the U.S. Department of Health and Human Services or the appropriate government agency.

(K) Services or supplies not prescribed by a physician or rendered by a covered practitioner.

(L) Vision examinations required by the employer as a condition of employment or which the employer is required to provide in compliance with a labor agreement, state or federal statute.

(M) Sun glasses.

(N) Safety glasses or goggles.

(O) Extra charges for photosensitive or anti-reflective lenses.

(P) Medical and/or surgical treatment of the eye.

(Q) Special procedures such as, but not limited to, orthoptics, vision training, or subnormal vision aids.

(R) Replacement of lost, stolen or broken lenses or frames.

(S) Examinations, or lenses and/or frames ordered before the covered person was eligible for coverage under this Plan or after coverage terminated.

ARTICLE 22.
GENERAL PLAN PROVISIONS

22.1 Entire Contract:

The entire contract between the Employer for the benefit of participating employees and their dependents and the **Plan** includes:

(A) This Plan document;

(B) Any attached rider, endorsement, or amendment; and

(C) The enrollment forms for covered persons.

22.2 Time Limit On Certain Defenses:

After such participating employee's and his dependent's coverage has been in force for 2 consecutive years during his lifetime:

(A) A covered person's coverage under this **Plan** will not be contested, except for nonpayment of contributions; and

(B) In the absence of fraud, no statement made by a covered person relating to his good health will be used to contest the validity of his coverage with respect to which statement was made.

No claim for loss incurred that begins after 2 years from the covered person's effective date will be reduced or denied on the grounds that disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such effective date.

22.3 Changes:

No change in the **Plan** will be valid unless approved by the Employer and Contract administrator. It must be

evidenced by endorsement on or amendment to this **Plan** signed by the Employer and Contract Administrator.

22.4 Summary Plan Description:

This Plan Document will also function as the Summary Plan Description. A copy of this Plan will be issued for delivery to each covered employee.

22.5 How to appeal a claim:

Claimants will be notified in writing by the Employer if a claim or any part of a claim is denied. The notice will include the specific reason or reasons for the denial of your claim, and the reference to the relevant Plan provisions on which the denial was based.

If you, as a claimant are not satisfied with the explanation of why the claim was denied, you may request to have your claim reviewed. Your request must be in writing to the Plan Administrator and made within sixty (60) days after the date you receive the notice denying your claim.

If you do not hear from the Plan Administrator within ninety (90) days after the Plan Administrator received your claim, you may consider your claim denied and request to have your claim reviewed.

A decision will be made within sixty (60) days after the receipt of your request for review or the date all information required from you is given.

22.6 Legal Actions:

No action at law or in equity may be brought to recover on this **Plan** prior to the expiration of 60 days

after written proof of loss is required to be filed. No such action will be brought after the expiration of 3 years after the time written proof of loss is required by this **Plan**.

22.7 Arbitration:

(A) As a condition precedent to any right of action hereunder, any dispute arising out of this **Plan** which is unresolved by the procedures outlined above shall be submitted to the decision of a board of arbitration ("the board") composed of two arbitrators and an umpire.

(B) The members of the Board of arbitration shall be active or retired disinterested officials of insurance or reinsurance companies other than the parties or their affiliates. Each party shall appoint its arbitrator, and the two arbitrators shall choose an umpire before instituting the hearing. If the respondent fails to appoint its arbitrator within 4 weeks after being requested to do so by the claimant, the claimant shall also appoint the second arbitrator. If the two arbitrators fail to agree upon the appointment of an umpire within 4 weeks after their nominations, each of them shall name three, of whom the other shall decline two and the decision shall be made by drawing lots.

(C) The claimant shall submit its initial statement within 20 days from appointment of the umpire. The respondent shall submit its statement within 10 days after receipt of the claimant's statement.

(D) The board shall make its decision with regard to the custom and usage of the insurance business. The board shall issue its decision in writing upon evidence introduced at a hearing

or by other means of submitting evidence in which strict rules of evidence need not be followed, but in which cross-examination and rebuttal shall be allowed if requested. The Board shall make its decision within 45 days following the termination of the hearings unless the parties consent to an extension. The majority decision of the board shall be final and binding upon all parties of the proceeding. Judgment may be entered upon the award of the board in any court having jurisdiction thereof.

(E) Each party shall bear the expense of its own arbitrator and shall jointly and equally bear with the other party the expense of the umpire. The remaining costs of the arbitration proceedings shall be allocated by the board.

22.8 Statements:

(A) All statements made by each covered person will be considered representations, not warranties. If any statement is incorrect or incomplete as to any covered person, coverage under the **Plan** may be rescinded.

(B) Any such representation will be used to void coverage or in defense of a claim under the **Plan**, unless it is a written statement, a copy of which has been furnished to the person or entity who made the statement.

22.9 Clerical Error/Delay:

Clerical errors made on the records of the Contract Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be solely in accordance with the

provisions of this **Plan**, regardless of whether any contributions with respect to covered persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made. Failure of the Employer to give notice of an employee's coverage request to the Contract Administrator is not considered to be clerical error.

22.10 Severability of Plan Provisions:

If a provision of this **Plan** is held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof and this **Plan** shall be construed and enforced as if such invalid or unenforceable provision had not been included.

22.11 Misrepresentation of Health Condition:

The Plan Administrator has the right to rescind the coverage of any Covered Person who has made a material misrepresentation of their health condition to the Plan Administrator.

22.12 Misstatement of Medical Fees:

Any misstatement of fees by a medical provider which are known to the employee at the time, and result in overpayment, become the responsibility of the employee.

22.13 Right of Reimbursement:

If a covered person is injured through the act or omission of another person, the **Plan** shall provide the benefits only on condition that the employee shall agree in writing:

(A) To reimburse the **Plan** to the extent of benefits provided, immediately upon collection of damages by him, whether by legal action, settlement, or otherwise, and including but not limited to motor vehicle insurance; and

(B) To provide the **Plan** with an Assignment of Benefits, to the extent of benefits provided by the **Plan**. The assignment of Benefits must be filed with the person whose act caused the injuries, his agent, the court, or the provider of the services.

(C) The employee's agreement is binding on his covered dependents also.

22.14 Reimbursement for Third Party Liability:

If a covered person if injured through the act or omissions of another person or organization, benefits under the **Plan** are provided on the condition that the covered person agree in writing:

(A) To reimburse for benefits paid under the **Plan** in excess of $1,000 immediately upon receipt of any damages collected against a third party, whether in a legal judgment, settlement, or otherwise, net of reasonable expenses in collecting that amount, including reasonable attorney's fees, and any amounts which are allocated under the terms of any judgment for the payment of unreimbursed medical expenses;

(B) To execute and deliver such instruments and do whatever else is reasonably necessary to secure the **Plan's** right to reimbursement of medical payments against a third party, whether in a legal judgment, settlement, or otherwise. Said lien and order must be equal to the total amount of all benefits paid under the **Plan**; and

(C) To agree to a credit against payment to be made under the **Plan** in the future equal to the amount of any damages collected by a third party, whether by legal judgment, settlement, or otherwise, less any amount paid to the **Plan**.

(D) The employee's agreement is also binding on his covered dependents.

If a covered person fails to comply with these requirements, that person will not be eligible to receive any further benefits under the **Plan** until he complies.

The **Plan** has the right to intervene at its own expense in any suit or other proceeding to protect these reimbursement rights. The covered individual is responsible for all fees of the attorney handling his or her claim against the third party.

ARTICLE 23.
STATEMENT OF ERISA RIGHTS

As a Participant in the **International Association of Entrepreneurs of America Employee Welfare Benefit Plan,** you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). ERISA provides that all Plan Participants shall be entitled to:

(1) examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan Documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

(2) Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the International Association of Entrepreneurs of America Employee Welfare Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the International Association of Entrepreneurs of America Employee Welfare Benefit Plan or exercising your rights under ERISA.

If your claim for a benefit under the Plan is denied in whole or part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the

materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored in whole or in part after arbitrating the claim as provided for under the Plan, you may file suit in a state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if the court finds your claim frivolous or without any merit, you may be ordered to pay such costs and fees.

If you have questions about your Plan, you should contract the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, U.S. Department of Labor.

EXHIBIT
C

INTERNATIONAL ASSOCIATION OF
ENTREPRENEURS OF AMERICA
BENEFIT TRUST

(A Trust established under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and subject to rules and regulations insured by the U.S. Department of Labor and the Internal Revenue Service)

PARTICIPATION AGREEMENT

The undersigned Employer hereby agrees to become a Participating Employer under the International Association of Entrepreneurs of America Benefit Trust ("Trust") created by an Agreement and Declaration of Trust to provide self-funded group coverage for eligible employees (and with respect to their eligible dependents) of employers who are engaged in the Construction, Service, Manufacturing, Retail, Wholesale, Agriculture, or Transportation industries or who provide services or supplies to those industries. The undersigned shall become a Participating Employer under the Trust effective upon approval of the undersigned Employer's request for participation in the Group Plan or Plans (the "Plan") by the Benefit Review Committee (BRC) or designated plan supervisor. If accepted as a Participating Employer, the undersigned agrees to be bound by the provisions of the Trust as now in effect or amended in the future.

The undersigned Employer agrees to:

– Maintain an enrollment of at least (1) 99% of the eligible employees and dependent units who share in the cost of coverage, or (2) 99% if now

or later, upon written application to the Plan, the employees do not share in the cost. (Voluntary or programs excepted.)

– Furnish any information required in the administration of the Trust.

– Hold open to inspection any records which have a bearing on the coverage or on the Undersigned.

If this application is not accepted by the BRC or the designated plan supervisor, any monies paid by or on account of the Undersigned shall be refunded and no coverage(s) will be issued.

The undersigned understands that the Trust document provides, among other things, that (1) the purpose of the Trust is to provide group coverage for eligible employees of Participating Employers and with respect to the eligible dependents of such employees, pursuant to the Plan issued by the Trust; (2) a Participating Employer's contribution to the Trust fund established under the Trust shall be in the amount specified by or on behalf of the Trustee; (3) the Plan, duly adopted by the BRC, the principal provisions of which are summarized in the Summary Plan Description and/or Certificate which is issued for delivery to covered employees contains the terms and conditions under which benefits are payable to each person entitled thereto; (4) benefits are available for a covered person with respect to conditions and limitations as set forth in the express provisions of the employee benefit Plan; (5) nominal legal title to the Trust shall be vested in the Trustee, possession and control of the Trust shall rest with the BRC; (6) the Trust or

BRC may authorize a plan supervisor to perform administrative functions in connection with the Plan.

It is understood and agreed that the undersigned's participation in the Trust shall terminate when the undersigned (a) fails to make a contribution payment within the time provided by the Plan document as adopted by the BRC, (b) ceases to qualify by reason of any State or Federal law, (c) fails to comply with the Participating Agreement, (d) gives the BRC or plan supervisor no less than thirty (30) days written notice prior to the contribution date on which the undersigned desires to terminate his participation in the Trust or if and when the Trustee is given written notice of the termination of the Trust, (e) coverage shall terminate when the BRC or plan supervisor terminates the Participating Employer's coverage. It is also understood that the participating employer is responsible for notifying its employees of any lapse or termination of coverage(s).

1. The coverage contracted for under this agreement is for employees of my firm which is in the (Check one):

   Construction Industry __ *Service Industry* ✓
   Manufacturing __ *Retail* __
   Wholesale __ *Agriculture* __
   Transportation __

2. These Employees are (Check one):

   Hourly Employees __ *Salaried Employees* __ *Both* ✓

3. As the employer, I agree to contribute toward the cost of coverage as follows (Check one):

Pay Entire Cost ✓ *Pay Full Employee Cost Only* __ *Provide Payroll Deduction* __

4. For salaried employees, the Waiting Period during which a new employee must be employed before becoming eligible for benefits is (Check one):

   N/A *30 Days* __ *60 Days* __ *90 Days* __ *180 Days* __

5. MEDICAL PLAN BENEFITS SELECTED
   A. __ *Plan II ($__ Deductible/50% Co-Payment)*
   B. __ *Plan III ($__ Deductible/80% Co-Payment)*
   OPTIONS: __ *Dental Care and Vision Care Benefits (available only under Plan III)*

COMBINED MANAGEMENT
Company Name

67 MINOT AVE. AUBURN, ME 04210 207) 782-8246
Company Address City State Zip Phone

SAME
Business Office Address City State Zip Phone

Contract Person Contact Person's Title

The undersigned employer understands and agrees that: (1) its participation in the International Association of Entrepreneurs of America Benefit Trust is subject to written approval of this application to participate; (2) No liability is created or assumed by the International Association of Entrepreneurs of American Benefit Trust until this application has been approved in writing; and (3) if for any reason this application is not so approved in writing the sole obligation of the International Association of Entrepreneurs of America Benefit Trust will be,

and the employer shall be entitled to only, a refund of any monies paid.

The undersigned employer further agrees and understands the coverage which is to be placed in force is subject to all of the provisions of the group plan including, without limitation of the foregoing, the right of the BRC or designated plan supervisor to inspect payroll and personnel records which may have a bearing on or be the basis for any coverage requested, or placed in force.

The undersigned employer understands that the Employee Welfare Benefit Plan (the "Plan") established under the Trust to which this application is made is a self-funded self-adjusting Plan established under ERISA. The undersigned employer further understands that neither the Trust or the Plan are an insurance company or insurance contract. The undersigned employer further understands that neither the Trust or the Plan is subject to regulation by any state insurance regulatory authority. The undersigned employer further understands that the Trust and the Plan are reserved for losses according to actuarial advice and formulas and reinsured with VIKING CASUALTY INSURANCE CO. to maintain financial solvency. VIKING CASUALTY INSURANCE CO. guarantees 100% of any losses of the Trust and the Plan under the reinsurance treaty between the Trust and the Plan and VIKING CASUALTY INSURANCE CO. The undersigned employer further understands that neither it nor the employee, dependent or beneficiary has any contractual relationship or any direct claim or cause of action against VIKING CASUALTY INSURANCE CO. Only the Trust and the Plan are liable to participating employers

and their employees, dependents and beneficiaries for losses arising under the Plan.

The undersigned employer understands and acknowledges that the Plan under which coverage is provided requires covered persons to obtain pre-certification to receive major medical benefits, and failure to obtain such pre-certification will result in substantial reduction in benefits.

This Participation Agreement is hereby executed on this 1 day of January, 1993, by:

EMPLOYER:

/s/ Richard Spugnardi
By:
Title: operation

PLAN SUPERVISION BY:

INTERNATIONAL ASSOCIATION OF
ENTREPRENEURS OF AMERICA
BENEFIT TRUST
ATTENTION: ROSS FULLER
3200 WEST END AVENUE, SUITE 500
NASHVILLE, TENNESSEE 37203
(615) 783-1750

UNITED STATES CODE
ANNOTATED

Title 29

Labor

§§ 801 to 1500

Comprising All Laws of a General and Permanent Nature Under Arrangement of Official Code of the Laws of the United States with Annotations from Federal and State Courts

ST. PAUL, MINN.
WEST PUBLISHING CO.

§ 1003. Coverage

(a) Except as provided in subsection (b) of this section and in sections 1051, 1081, and 1101 of this title, this subchapter shall apply to any employee benefit plan if it is established or maintained –

(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or

(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or

(3) by both.

(b) The provisions of this subchapter shall not apply to any employee benefit plan if –

(1) such plan is a governmental plan (as defined in section 1002(32) of this title);

(2) such plan is a church plan (as defined in section 1002(33) of this title) with respect to

which no election has been made under section 410(d) of Title 26;

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;

(4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or

(5) such plan is an excess benefit plan (as defined in section 1002(36) of this title) and is unfunded.

(Pub.L. 93-406, Title I, § 4, Sept. 2, 1974, 88 Stat. 839.)

* * *

§ 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and

familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

(2) In the case of an eligible individual account plan (as defined in section 1107(d)(3) of this title), the diversification requirement of paragraph (1)(C) and the prudence requirement (only to the extent that it requires diversification) of paragraph (1)(B) is not violated by acquisition or holding of qualifying employer real property or qualifying employer securities (as defined in section 1107(d)(4) and (5) of this title).

(b) Indicia of ownership of assets outside jurisdiction of district courts

Except as authorized by the Secretary by regulation, no fiduciary may maintain the indicia of ownership of any assets of a plan outside the jurisdiction of the district courts of the United States.

(c) Control over assets by participant or beneficiary

In the case of a pension plan which provides for individual accounts and permits a participant or beneficiary to exercise control over the assets in his account, if a participant or beneficiary exercises control over the assets in his account (as determined under regulations of the Secretary) –

> **(1)** such a participant or beneficiary shall not be deemed to be a fiduciary by reason of such exercise, and
>
> **(2)** no person who is otherwise a fiduciary shall be liable under this part for any loss, or by reason of any breach, which results from such participant's or beneficiary's exercise of control.

(Pub.L. 93-406, Title I, § 404, Sept. 2, 1974, 88 Stat. 877; Pub.L. 96-364, Title III, § 309, Sept. 26, 1980, 94 Stat. 1296.)

* * *

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section –

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts.

(6)(A) Notwithstanding any other provision of this section –

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides –

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law

able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully

insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title).

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections

1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(Pub.L. 93-406, Title I, § 514, Sept. 2, 1974, 88 Stat. 897; Pub.L. 97-473, Title III, §§ 301(a), 302(b), Jan. 14, 1983, 96 Stat. 2611, 2613; Pub.L. 98-397, Title I, § 104(b), Aug. 23, 1984, 98 Stat. 1436.)

UNITED STATES CODE
ANNOTATED

Title 29
Labor
§§ 801 to 1500

1994
Supplementary Pamphlet

Covering Years 1986 to 1993
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* * *

§ 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

[See main volume for text of (A) to (C)]

(D) In accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with

the provisions of this subchapter and subchapter III of this chapter.

[See main volume for text of (2); (b) and (c)]

(d) Plan terminations

(1) If, in connection with the termination of a pension plan which is a single-employer plan, there is an election to establish or maintain a qualified replacement plan, or to increase benefits, as provided under section 4980(d) of Title 26, a fiduciary shall discharge the fiduciary's duties under this subchapter and subchapter III of this chapter in accordance with the following requirements:

(A) In the case of a fiduciary of the terminated plan, any requirement –

(i) under section 4980(d)(2)(B) of Title 26 with respect to the transfer of assets from the terminated plan to a qualified replacement plan, and

(ii) under section 4980(d)(2)(B)(ii) or 4980(d)(3) of Title 26 with respect to any increase in benefits under the terminated plan.

(B) In the case of a fiduciary of a qualified replacement plan, any requirement –

(i) under section 4980(d)(2)(A) of Title 26 with respect to participation in the qualified replacement plan of active participants in the terminated plan,

(ii) under section 4980(d)(2)(B) of Title 26 with respect to the receipt of assets from the terminated plan, and

(iii) under section 4980(d)(2)(C) of Title 26 with respect to the allocation of assets to participants of the qualified replacement plan.

(2) For purposes of this subsection –

(A) any term used in this subsection which is also used in subsection 4980(d) of Title 26 shall have the same meaning as when used in such section, and

(B) any reference in this subsection to Title 26 shall be a reference to Title 26 as in effect immediately after the enactment of the Omnibus Budget Reconciliation Act of 1990.

(As amended Pub.L. 101-508, Title XII, § 12002(b)(1), (2)(A), Nov. 5, 1990, 104 Stat. 1388-565, 1388-566.)

* * *

§ 1144. Other laws

[See main volume for text of (a)]

(b) Construction and application

[See main volume for text of (1) to (5)(B)]

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials

of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section –

[See main volume for text of (i) and (ii), (B) and (C)]

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State, qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent enforced by qualified medical child support orders.

[See main volume for text of (7)]

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action –

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed

before payment with respect to such items or services by the group health plan.

[See main volume for text of (c) and (d)]

(As amended Pub.L. 99-272, Title IX, § 9503(d)(1), Apr. 7, 1986, 100 Stat. 207; Pub.L. 101-239, Title VII, § 7894(f)(2)(A), (3)(A), Dec. 19, 1989, 103 Stat. 2450, 2451; Pub.L. 103-66, Title IV, § 4301(c)(4), Aug. 10, 1993, 107 Stat. 377.)

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CHAPTER 125

EMPLOYEE LEASING COMPANIES

Section		Section	
14051.	Definitions.	14055.	Insurance; unemployment insurance; benefit plans.
14052.	Registration required.	14056.	Exemption.
14053.	Registration process.	14057.	Advertising prohibition.
14054.	Fees.	14058.	Penalties.

* * *

§ 14051. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. **Client company.** "Client company" means a person, association, partnership, corporation or other entity that leases employees from an employee leasing company pursuant to contract.

2. **Controlling person.** "Controlling person" means:

A. A person or entity that owns a 5% or greater interest in an employee leasing company or possesses, directly or indirectly, the power to direct or cause the direction of the management or policies of an employee leasing company through ownership of voting securities, by contract or otherwise, and is actively involved in the day-to-day management of the company; or

B. A natural person employed, appointed or authorized by an employee leasing company to enter into a contractual relationship with a client company on behalf of the employee leasing company.

3. **Employee leasing company.** "Employee leasing company" means a sole proprietorship, partnership, corporation or other form of business entity, a substantial portion of the business of which consists of leasing employees to one or more client companies under contractual arrangements that are characterized by the following.

A. Employment responsibilities are carried out by the employee leasing company or are shared

by the employee leasing company and the client company.

B. Direction and control of employees provided by the employee leasing company are handled by the employee leasing company or are shared by the employee leasing company and the client company. "Direction and control" includes the right of the employee leasing company to hire and fire employees.

C. The leasing arrangement is long term and does not include arrangements to provide temporary help services. "Temporary help services" means a service whereby an organization hires its own employees and assigns them to a 3rd party to support or supplement the 3rd party's work force in work situations such as employee absences, temporary skill shortages, seasonal work load conditions and special assignments and projects.

D. The leasing arrangement does not include providing labor dispute workers. "Labor dispute worker" means a worker who is furnished to an entity to replace workers involved in strikes, lockouts or other labor activities.

4. Registrant. "Registrant" means an employee leasing company that registers under this chapter.

5. Superintendent. "Superintendent" means the Superintendent of Insurance.

1991, c. 468, § 4.

* * *

§ 14055. Insurance; unemployment insurance; benefit plans

1. Benefits. The following provisions govern the provision of benefits by employee leasing companies to their employees.

A. Any employee welfare plan or benefit, other than workers' compensation insurance, provided by an employee leasing company to employees leased to a client company, whether the plan or benefit is supplied through insurance or self-funding, is a plan or benefit provided by the employee leasing company as employer to those employees for purposes of state laws applicable to employee benefits, including group insurance coverage under Title 24-A, chapters 31,[1] 35 [2] and 38.[3]

B. The superintendent shall adopt rules governing the provision of workers' compensation insurance as required by Title 39-A, chapter 9[4] for workers provided by an employee leasing company to any client company. These rules must be consistent with subsection 2 and reflect consideration of the needs and operational efficiencies of employee leasing companies and the costs to the workers' compensation system. If either the employee leasing company or the client company has secured the payment of compensation in conformity with former Title 39,

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[1] Section 2601 et seq. of title 24-A.

[2] Section 2801 et seq. of title 24-A.

[3] Section 2881 et seq. of title 24-A.

[4] Section 401 et seq. of title 39-A.

chapter 1[5] or Title 39-A, chapter 9, the immunity from liability described in that chapter extends to and is binding on the client company, the employee leasing company, all employees leased to any client company and any other employees of the employee leasing company or the client company. An employee leasing company is not responsible for securing the payment of compensation in conformity with Title 39-A[6] nor deprived of the defenses listed in Title 39-A, section 103 with respect to those persons for whom the provision of benefits is not required under Title 39-A in the absence of an employee leasing arrangement.

2. Workers' compensation. Workers' compensation insurance for employees leased to client companies is subject to the following.

A. Under rules adopted pursuant to subsection 1, paragraph B, the superintendent may provide a determination of the circumstances and conditions, if any, under which an employee leasing company may be the policy holder of a workers' compensation insurance policy providing coverage to employees leased to client companies. Additionally or alternatively, the superintendent may require by rule that:

> **(1)** The employee leasing company purchase separate policies through the Maine Employers' Mutual Insurance Company, established pursuant to Title 24-A, section 3703, for client companies subject to Title 39-A;[6] and

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[5] Repealed. Former § 1 et seq. of title 39.

[6] Section 101 et seq. of title 39-A.

(2) The policies be assigned to one servicing carrier and, to the extent practical, administered on a unified basis. The superintendent also may provide by rule that the employee leasing company or the President of the Maine Employers' Mutual Insurance Company request from the superintendent a waiver of a rule adopted pursuant to this subparagraph if it is impractical for one servicing carrier to service all the client companies of an employee leasing company.

B. When workers' compensation coverage is provided by means of insurance maintained by the employee leasing company through the residual market mechanism, the rules may further provide for the application of experience modification factors, premium surcharges and deductibles consistent with Title 24-A, section 2366. To the extent that a workers' compensation insurance policy is issued to an employee leasing company, experience modification factors applicable to a company that becomes a client company of the employee leasing company after the effective date of this section are calculated by using the client company's experience modification factor:

(1) Throughout the term of the employee leasing arrangement; or

(2) For no more than the first 3 years of the employee leasing arrangement if the requirements of the rules adopted by the superintendent are met.

C. Each employee leasing company that carries workers' compensation insurance for its leased employees shall maintain and make available to its workers' compensation carrier information

required by rules adopted by the superintendent pursuant to this chapter. An employee leasing company shall promptly notify its workers' compensation insurance carrier and the residual market manager of the termination of the employee leasing company's relationship with any client company for which it provides workers' compensation insurance.

3. Unemployment insurance. An employee leasing company's responsibility for unemployment insurance is governed by Title 26, section 1221-A and as follows.

A. During the term of the leasing arrangement, the employee leasing company is responsible for payment of unemployment contributions, penalties and interest due pursuant to Title 26, chapter 13[5] on wages paid to employees leased to client companies, except for compensation paid to sole proprietors of or partners in the client company.

B. The employee leasing company shall report all unemployment contributions due under its state employer identification number, using its contribution rate. The employee leasing company shall keep separate records and submit separate quarterly wage reports to the Bureau of Employment Security for each of its client companies.

4. Other insurance. Employees leased to a client company by an employee leasing company remain the employees of the client company for purposes of general liability insurance, automobile insurance, fidelity bonds, surety bonds and employer's liability insurance carried by the client company. Employees leased to a client company by an employee leasing company are not deemed

employees of the employee leasing company for purposes of general liability insurance, automobile insurance, fidelity bonds, surety bonds or employer's liability insurance carried by the employee leasing company unless the employees are included by specific reference in the applicable insurance contract or bond.

5. Disclosure. The employee leasing company shall disclose to client companies services to be rendered, including costs, and the respective rights and obligations of the parties prior to entering into or receiving a leasing arrangement. This disclosure must include a statement that the client company may take complaints to the Bureau of Insurance.

1991, c. 468, § 4; 1991, c. 885, §§ E-42, E-43 eff. Jan. 1, 1993.

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Maine
REVISED STATUTES ANNOTATED

Volume 16B
Title 38

§ 1061 to End

Title 39

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* * *

§ 401. Liability of employer

1. Private employers. Every private employer is subject to this Act and shall secure the payment of a compensation in conformity with this section and sections 402 to 407 with respect to all employees, subject to the provisions of this section.

A private employer who has not secured the payment of compensation under this section and sections 402 to 407 is not entitled, in a civil action brought by an employee or the employee's representative for personal injuries or

death arising out of and in the course of employment, to the defense set forth in section 103. The employee of any such employer may, instead of bring a civil action, claim compensation from the employer under this Act.

The following employers are not liable under this section for securing the payment of compensation in conformity with this section and sections 402 to 407 with respect to the employees listed, nor deprived of the defenses listed in section 103:

A. Employers of employees engaged in domestic service;

B. Employers of employees engaged in agriculture or aquaculture as seasonal or casual laborers, if the employer maintains coverage by an employer's liability insurance policy with total limits of not less than $25,000 and medical payment coverage of not less than $1,000.

(1) As used in this subsection, "casual" means occasional or incidental. "Seasonal" refers to laborers engaged in agricultural or aquacultural employment beginning at or after the commencement of the planting or seeding season and ending at or before the completion of the harvest season; and

C. Employers of 6 or fewer agricultural or aquacultural laborers, if the employer maintains an employer's liability insurance policy with total limits of not less than $100,000 multiplied by the number of agricultural or aquacultural laborers employed by that employer and medical payment coverage of not less than $1,000.

(1) In computing the number of agricultural or aquacultural laborers under this

paragraph, immediate family members of unincorporated employers, immediate family members of bona fide owners of at least 20% of the outstanding voting stock of an incorporated agricultural employer and seasonal and casual workers are not included. For the purposes of this subparagraph, "immediate family members" means parents, spouse, brothers, sisters and children.

(2) This exemption does not apply if the employer has employed more than 6 agricultural or aquacultural laborers in regular and concurrent manner, as computed under subparagraph 1, at any time during the 52 weeks immediately preceding the injury.

The burden of proof to establish an exempt status under this subsection is on the employer claiming the exemption.

2. Governmental bodies. The State and every county, city and town is subject to this Act and shall secure the payment of compensation in conformity with sections 402 to 407.

3. Failure to conform. The failure of any private employer not exempt under subsection 1 or of any governmental body, as defined in subsection 2, to procure insurance coverage for the payment of compensation pursuant to sections 402 to 407 constitutes failure to secure payment of compensation provided for by this Act within the meaning of section 324, subsection 3, and subjects the employer to the penalties prescribed by that section. For purposes of this subsection, the term "insurance coverage" includes authorization by the Superintendent of Insurance to self-insure.

4. Liability of landowner. A landowner subject to this Act who contracts to have wood harvested from the landowner's property by a contractor who, as an employer, is subject to this Act and who has not complied with the provisions of this section and who does not comply with the provisions of this section prior to the date of an injury or death for which a claim is made is liable to pay to any person employed by the contractor in the execution of the work any compensation under this Act that the landowner would have been liable to pay if that person had been immediately employed by the landowner.

A landowner is not liable for compensation if at the time the landowner enters into the contract with the contractor, the landowner applies for and receives a predetermination of the independent status of the contractor as set forth in section 105, or the landowner requests and receives a certificate of insurance, issued by the contractor's insurance carrier, certifying that the contractor has obtained the required coverage and indicating the effective dates of the policy, and if the landowner requests and receives at least annually similar certificates indicating continuing coverage during the performance of the work. A landowner who receives a predetermination of the contractor's status as independent contractor is only relieved of liability under this paragraph if the contract for wood harvesting expressly states that the independent contractor will not hire any employees to assist in the wood harvesting without first providing the required certificate of insurance to the landowner.

Notwithstanding section 105, subsection 1, paragraph A, a predetermination under section 105 related only to parties subject to this subsection is a conclusive presumption that the determination is correct and section 105, subsection 2 does not apply to that determination. Each party involved in or affected by the predetermination must be provided information on the workers' compensation laws and the effect of independent contractor status in relation to those laws. A predetermination under section 105 related to parties subject to this subsection is effective for one calendar year or the duration of the contract, whichever is shorter.

A landowner required to pay compensation under this section is entitled to be indemnified by the contractor and may recover the amount paid in an action against that contractor. A landowner may demand that the contractor enter into a written agreement to reimburse the landowner for any loss incurred under this section due to a claim filed for compensation and other benefits. The employee is not entitled to recover at common law against the landowner for any damages arising from such injury if the employee takes compensation from that landowner.

Landowners willfully acting for circumvent the provisions of this section by using coercion, intimidation, deceit or other means to encourage persons who would otherwise be considered employees within the meaning of this Act to pose as contractors for the purpose of evading this section are liable subject to the provisions of section 324, subsection 3. Nothing in this section may be

construed to prohibit an employee from becoming a contractor subject to the provisions of section 102, subsection 13.

5. Workplace health and safety training programs. The following workplace health and safety plan requirements apply to all employers in the State required to secure payment of compensation in conformity with this Title.

A. The Commissioner of Labor or the commissioner's designee shall adopt rules regarding workplace health and safety programs.

B. The Superintendent of Insurance shall communicate to the Department of Labor the names of employers that receive in any policy year an experience rating of 2 or more. The Department of Labor shall notify each employer on that list that the employer is required to undertake a workplace health and safety program and the department shall provide a statistical evaluation of the employer's workplace health and safety experience and enclose a set of workplace health and safety options, including on-site consultation, education and training activities and technical assistance.

C. The employer shall submit a workplace health and safety plan to the Department of Labor for review and comment, complete the elements of the plan and notify the Department of Labor of its completion. The plan may include attendance at a technical college in the State or the Department of Labor workplace health and safety training programs.

D. The Department of Labor shall notify the Superintendent of Insurance of any employer

that fails to complete the workplace health and safety program as required by this section and the rules adopted pursuant to paragraph A. The Superintendent of Insurance shall assess a surcharge of 1(on that employer's workers' compensation insurance premium or the imputed premium for self-insurers, which must be paid to the Treasurer of State who shall credit 1/2 of that amount to the Safety Education and Training Fund, as established by Title 26, section 61, and 1/2 to the Occupational Safety Loan Fund, as established by Title 26, section 62. Employers who fail to complete a required workplace health and safety program and who are assessed a surcharge prior to January 1, 1994, must be assessed a surcharge of 5%. Employers who fail to complete a required workplace health and safety program and who are assessed a surcharge after January 1, 1994, must be assessed a surcharge of 10%.

E. The Commissioner of Labor shall report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters and the joint standing committee of the Legislature having jurisdiction over labor matters by October 1, 1993 on the rules adopted, performance by employers and any surcharges imposed by the Superintendent of Insurance.

1991, c. 885, § A-8, eff. Jan. 1, 1993; 1993, c. 120, § 2, eff. May 12, 1993.

* * *

§ 403. Insurance by assenting employer; requirements as to self-insurers

An employer subject to this Act shall secure compensation and other benefits to the employer's employees in one or more of the ways described in this section. The failure of any employer subject to this Act to procure insurance coverage for the payment of compensation and other benefits to the employer's employees in one of the ways described in this section constitutes failure to secure payment of compensation provided for by this Act within the meaning of section 324, subsection 3 and subjects the employer to the penalties prescribed by that section.

1. Insuring under workers' compensation insurance policy. The employer may comply with this section by insuring and keeping insured the payment of such compensation and other benefits under a workers' compensation insurance policy. The insurance company shall file with the board notice, in the form required by the board, of the issuance of any workers' compensation policy to an employer. The insurance may not be cancelled within the time limited in such policy for its expiration until at least 30 days after the insurance company mails to the board and to the employer a notice of the cancellation of the insurance. In the event that the employer has obtained a workers' compensation policy from another insurance company, or has otherwise secured compensation as provided in this section, and such insurance or other security becomes effective prior to the expiration of the 30-day notice period, cancellation takes effect on the effective date of the other insurance or on receipt of security.

2. Pilot projects. Workers' compensation health benefits pilot projects are authorized under the following provisions.

A. The Superintendent of Insurance shall adopt rules to enable employers and employees to enter into agreement to provide the employees with health care benefits covering workplace injury and illness and nonworkplace injury and illness and other health care benefits in comprehensive pilot projects. The health care benefits may be provided by: organizations authorized to do business under Title 24; insurers or health maintenance organizations authorized to do business under Title 24-A; employee benefit plans; and benefit plans of employers who self-insure under this section. The superintendent shall review all pilot project proposals and may approve a proposal only if it confers medical benefits upon injured employees substantially similar to benefits available under this Title. The superintendent shall revoke approval if the pilot project fails to deliver the intended benefits to the injured employees.

B. Notwithstanding the provisions of section 206, the comprehensive health care benefits pilot project may allow for case management and cost control mechanisms, including the use of preferred provider organizations. The premium for coverage of the employee must be paid entirely by the employer. The deductible for the health care of the employee may not exceed a maximum of $50 per injury or illness and the coinsurance may not exceed $5 per treatment of the employee by the health care provider.

C. The Superintendent of Insurance shall report annually to the joint standing committees of the Legislature having jurisdiction over banking and insurance and labor matters by November 1st on the status of any pilot projects approved by the superintendent.

D. Unless continued or modified by law, this subsection is repealed on October 31, 1996.

3. **Proof of solvency and financial ability to pay; trust.** The employer may comply with this section by furnishing satisfactory proof to the Superintendent of Insurance of solvency and financial ability to pay the compensation and benefits, and depositing cash, satisfactory securities, irrevocable standby letters of credit issued by a qualified financial institution or a surety bond with the board, in such sum as the superintendent may determine pursuant to subsection 8, such bond to run to the Treasurer of State and to be conditional upon the faithful performance of this Act relating to the payment of compensation and benefits to any injured employee. In case of cash or securities being deposited, the cash or securities must be placed in an account at interest by the Treasurer of State, and the accumulation of interest on the cash or securities so deposited must be credited to the account and may not be paid to the employer to the extent that the interest is required to support any present value discounting in the determination of the amount of the deposit. Any security deposit must be held by the Treasurer of State in trust for the benefit of the self-insurer's employees for the purposes of making payments under this Act.

An individual self-insurer may, with the approval of the superintendent, use a surety bond, an irrevocable standby letter of credit or financial assets, including cash deposits and acceptable securities, singly or in combination to satisfy the self-insurer's responsibility to post security required by the superintendent. An individual self-insurer that proposes to use an irrevocable standby letter of credit shall maintain at all times a net worth of not less than $50,000,000, have a ratio of current assets to current liabilities of at least 1.1 to 1 and have a ratio of iong term debt to tangible net worth not in excess of 1.3 to 1. For purposes of this section, "tangible net worth" means equity less assets that have no physical existence and depend on expected future benefits for their ascribed value.

An employer who seeks to use an irrevocable standby letter of credit as proof to the superintendent of provision of required security shall file with the superintendent a copy of the proposed letter of credit, copies of any agreements or other documents establishing the terms and conditions of the employer's reimbursement obligations to the financial institution issuing the letter of credit, together with copies of any required security agreements, mortgages or other agreements or documents granting security for the employer's reimbursement obligations and any other agreements that contain conditions, restrictions or limitations of any kind upon the employer, the superintendent or the Treasurer of State. The superintendent, upon receipt of the original irrevocable standby letter of credit, shall promptly forward it to the Treasurer of State.

The superintendent shall adopt rules to establish the qualifications for financial institutions issuing irrevocable standby letters of credit, which must include maintenance of a long-term unsecured debt rating of at least A by either Moody's Investors Service, Inc. or Standard and Poor's Corporation, and to prescribe the form of the irrevocable standby letter of credit that may be used to satisfy, in whole or in part, the employer's responsibility under the subsection to post security. The irrevocable standby letter of credit must be the individual obligation of the issuing financial institution, may not be subject to any agreement, condition or qualification between the financial institution and the employer and may not in any way be contingent on reimbursement by the employer. If the rating of an issuing financial institution that has issued an irrevocable standby letter of credit pursuant to this section falls below the required standard, the employer must obtain a new irrevocable standby letter of credit from a qualified financial institution or must provide substitute proof of solvency and financial ability to pay consistent with this section. The irrevocable standby letter of credit is automatically extended for one year from the date of expiration unless, 90 days prior to any expiration date, the issuing financial institution notifies the superintendent that the financial institution elects not to renew the irrevocable standby letter of credit.

An irrevocable standby letter of credit that has been issued by a qualified financial institution and accepted by the superintendent binds the issuing financial institution to pay one or more drafts drawn by the Treasurer of State as long as the draft does not exceed the total amount of

the irrevocable standby letter of credit. Any draft presented by the Treasurer of State must be promptly honored if accompanied by the certification of the superintendent that any obligation under this chapter has not been paid when due or that a proceeding in bankruptcy has been initiated by or with respect to the employer in a court of competent jurisdiction.

If the superintendent certifies that the superintendent has been notified by the issuing financial institution that the irrevocable standby letter of credit will expire by its terms in 30 days or less, that the irrevocable standby letter of credit was not replaced within 15 days after that notice to the superintendent by a substitute irrevocable standby letter of credit and that other eligible security of equal value has not been posted, then the full amount of the irrevocable letter of credit must be paid over the Treasurer of State without further certification.

Any proceeds from a draw on such an irrevocable standby letter of credit by the Treasurer of State must be held by the Treasurer of State on behalf of workers' compensation claimants to secure payment of claims until either the Superintendent of Insurance authorizes the Treasurer of State to release those proceeds to the employer upon provision by the employer of replacement security adequate to meet the requirements for security set by the superintendent or the superintendent directs distribution of the proceeds in accordance with this Title.

The Superintendent of Insurance shall consider the following form of letter acceptable.

IRREVOCABLE STANDBY LETTER OF CREDIT

Irrevocable standby letter of credit no. ____

We hereby issue our irrevocable standby letter of credit (hereinafter referred to as "letter of credit") in favor of the Treasurer of State, State of Maine for drawings up to U.S. $____ effective immediately and expiring immediately at our _____ (bank address) _____ with our close of business on _____

We hereby undertake to honor promptly your sight draft(s) drawn on us, indicating our letter of credit no. ____ for all or part of this letter of credit if presented at _____ (bank address) _____ on or before the expiration date or any automatically extended date.

Except as stated in this letter of credit, this undertaking is not subject to any condition or qualification. The obligation of the bank under this letter of credit is the individual obligation of the bank, in no way contingent upon reimbursement with respect thereto.

It is a condition of this letter of credit that it is automatically extended without amendment for one year from the expiration of this letter of credit, or any future expiration date, unless 90 days prior to any expiration date we notify the Chair of the Workers' Compensation Board and the Superintendent of Insurance by registered mail that we elect not to consider this letter of credit renewed for any additional period.

It is a further condition of this letter of credit that any interruptions of the bank's conduct of business caused by an Act of God, riot, civil commotion, insurrection, war or other cause beyond the bank's control will automatically

> extend the expiration date of the letter of credit, as well as any future expiration date, by the period of the interruption.
>
> To the extent not inconsistent with Maine law, this letter of credit is subject to and governed by the Uniform Customs and Practice for Documentary Credits, 1983, International Chamber of Commerce Publication No. 400. If any legal proceedings are initiated with respect to payment of this letter of credit, it is agreed that such proceedings are subject to Maine courts and law.

The superintendent shall prescribe the form of the surety bond that may be used to satisfy, in whole or in part, the employer's responsibility under this section to post security. The bond must be continuous, be subject to nonrenewal only upon not less than 60 days' notice to the superintendent and cover payment of all present and future liabilities incurred under this Act while the bond is in force and cover payments that become due while the bond is in force that are attributable to injuries incurred in prior periods and otherwise unsecured by cash, irrevocable standby letters of credit or acceptable securities. A bond must be held until all payments secured thereby have been made or until it has been replaced by a bond issued by a qualified successor surety that covers all outstanding liabilities. Payments under the bond are due within 30 days after notice has been given to the surety by the board that the principal has failed to make a payment required under the terms of an award, agreement or governing law. A trust established to satisfy the requirements of this section may not be funded by a surety bond. An irrevocable standby letter of credit may be utilized by a group self-insurer that maintains a trust

account actuarially funded to the 90% confidence level as long as the value of the letter of credit does not exceed 5% of the value of the 90% confidence level.

As an alternative to the methods described in this subsection, an eligible employer may establish an actuarially fully funded trust, funded at a level sufficient to discharge those obligations incurred by the employer pursuant to this Act as they become due and payable from time to time, provided that the superintendent requires that the value of trust assets be at least equal to the present value of ultimate expected incurred claims and claims settlement costs. The present value of ultimate expected incurred claims and claims settlement costs for a group self-insurer may not be more than the amount actuarially determined considering the value of trust assets and reinsurance to satisfy a 90% confidence level. A group self-insurer may elect to fund at a higher confidence level through the use of cash, marketable securities or excess insurance. If a member of a group self-insurer terminates membership in the group for any reason, then that member shall fund the member's proportionate share of the liabilities and obligations of the trust to the 95% confidence level. If for any reason the departing member fails to fund the member's proportionate share of the trust's exposure to the 95% level of confidence, then the remaining members of the group shall make such additional contribution no later than the anniversary date of the program as required to fund the departing member's exposure in accordance with this provision. Trust assets must consist of cash or marketable securities of a type and risk character as specified in subsection 9 and have a situs in the United States. The trustee shall

submit a report to the superintendent not less frequently than quarterly that lists the assets comprising the corpus of the trust, including a statement of their market value and the investment activity during the period covered by the report. The trust must be established and maintained subject to the condition that trust assets may not be transferred or revert in any manner to the employer except to the extent that the superintendent finds that the value of the trust assets exceeds the present value of incurred claims and claims settlement costs with an actuarially indicated margin for future loss development. In all other respects, the trust instrument, including terms for certification, funding, designation of trustee and payout, must be as approved by the superintendent, provided that the value of the trust account must be actuarially calculated at least annually by a casualty actuary who is a member of the American Academy of Actuaries and adjusted to the required level of funding. For purposes of this paragraph, an "eligible employer" is one who is found by the superintendent to be capable of paying compensation and benefits required by this Act and:

A. Has positive net earnings; or

B. Can demonstrate a level of working capital adequate in relation to the employer's operating needs.

Notwithstanding any provision of this chapter, any bond or security deposit required of a public employer that is a self-insurer may not exceed $50,000, provided that such public employer has a state-assessed valuation equal to or in excess of $300,000,000 and either a bond rating equal to or in excess of the 2nd highest standard as set by

a national bond rating agency or a net worth equal to or in excess of $25,000,000. If a county, city or town relies upon a bond rating, it shall value or cause to be valued its unpaid workers' compensation claims pursuant to sound accepted actuarial principles. This value must be incorporated in the annual audit of the county, city or town together with disclosure of funds appropriated to discharge incurred claims expenses. "Public employer" includes the State, the University of Maine System, counties, cities and towns.

In consideration of a self-insuring entity's application for authorization to operate a plan of self-insurance, the superintendent may require or permit an applicant to employ valid risk transfer by the utilization of primary reinsurance, subject to the provisions of subsection 8. Standards respecting the application of reinsurance must be contained in a rule adopted by the superintendent pursuant to the Maine Administrative Procedure Act.[1] Reinsurance must be defined as insurance covering workers' compensation exposures in excess of risk retained by a self-insurer.

As a further alternative to the methods described in this subsection, an employer is eligible for approval self-insurance status pursuant to this Act if the employer submits a written guarantee of the obligations incurred pursuant to this Act, the guarantee to be issued by a United States or Canadian corporation that is a member of an affiliated group of which the employer is a member, and which corporation is solvent and demonstrates an

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[1] See 5 M.R.S.A. § 8001.

ability to pay the compensation and benefits, and the guarantee is in a form acceptable to the superintendent. The guarantor shall provide quarterly financial statements, audited annual financial statements and such other information as the superintendent may require, and the employer shall provide a bond as otherwise required by this Act in an amount not less than $1,000,000. Any such guarantor is deemed to have submitted to the jurisdiction of the board and the courts of this State for purposes of enforcing any such guarantee. The guarantor, in all respects, is bound by the subject to the orders, findings, decisions or awards rendered against the employer for payment of compensation and any penalties or forfeitures provided under this Act. The superintendent, following hearing, may revoke the self-insured status of the employer if at any time the assets of the guarantor become impaired, encumbered or are otherwise found to be inadequate to support the guarantee.

Each individual self-insurer shall submit with its application and not less frequently than annually thereafter a financial statement of current origin that has been audited by a certified public accountant. In the case of a self-insurer that qualifies on the basis of a financial guarantee, the superintendent may accept an audited financial statement of the guarantor in satisfaction of this requirement if combining statements are provided in an array that is reconciled to the consolidated report unless the self-insured entity comprises such a minimal proportion of total consolidated operations that audit reliance can not be taken therefrom.

4. Group self-insurers; application. Except for the provision relating to individual public employer self-

insurers, subsection 3 is equally applicable in all respects to group self-insurers. Any employer or group of employers desiring to become a self-insurer shall submit to the Superintendent of Insurance with an application for self-insurance, in a form prescribed by the superintendent, the following:

A. A payroll report for each participating employer of the group for the 3 preceding annual fiscal periods;

B. A report of compensation losses incurred, payments plus reserves, by each participating employer of the group for the periods described in paragraph A;

C. A sworn itemized statement of the group's assets and liabilities; satisfactory proof of financial ability to pay compensation for the employers participating in the group plan; and the group's reserves, their source and assurance of continuance;

D. A description of the safety organization maintained by the employer or group for the prevention of injuries;

E. A statement showing the kind of operations performed or to be performed;

F. An indemnity agreement in a form prescribed by the superintendent that jointly and severally binds the group and each member to comply with the provisions of this Act; and

G. Any other agreements, contracts or other pertinent documents relating to the organization of the employers in the group.

If, upon examination of the sworn financial statement and other data submitted, the superintendent is satisfied as to the ability of the employer or group to make current compensation payments and that the employer's or group's tangible assets make reasonably certain the payment of all obligations that may arise under this Act, the application must be granted subject to the terms and conditions setting out the exposure of cash deposits or securities or an acceptable surety bond, as required by the superintendent. Security against shock or catastrophe loss must be provided either by depositing securities with the board in such amount as the superintendent may determine or by filing with the superintendent and the board an insurance carrier's certificate of a standard self-insurer's reinsurance contract issued to the self-insurer or group in a form approved by the superintendent, providing coverage against losses arising out of one injury in such amounts as the superintendent may determine, or a combination of the foregoing, satisfactory to the superintendent. Notwithstanding any provision of this chapter, no specific or aggregate reinsurance may be required of any individual public employer who is self-insured and has a state-assessed valuation equal to or in excess of $300,000,000 and either a net worth equal to or in excess of $25,000,000 or a bond rating equal to or in excess of the 2nd highest standard as set by a national bond rating organization, provided that, if the self-insurer relying on a bond rating is a county, city or town, it shall value or cause to be valued its unpaid workers' compensation claims pursuant to sound accepted actuarial principles. This value must be incorporated in the annual audit of

the county, city or town together with disclosure of funds appropriated to discharge incurred claims expenses.

Yearly reports in a form prescribed by the superintendent must be filed by each self-insurer or group. The superintendent may, in addition, require the filing of quarterly financial status reports whenever the superintendent has reason to believe that there has been a deterioration in the financial condition of either an individual or group self-insurer that adversely affects the individual's or group's ability to pay expected losses. The reports must be filed within 30 days after the superintendent's request or at such time as the superintendent shall otherwise set.

After approving any application for self-insurance, the superintendent shall promptly notify the board and forward to it copies of the application and all supporting materials.

5. Group self-insurance; participation. Participation in a group self-insurance plan is governed by the following provisions.

> **A.** Any group of employers may adopt a plan for self-insurance, as a group, for the payment of compensation under this Act to their employees. No group may be approved to operate a self-insurance plan in the form of a corporation. Under a group self-insurance plan the group shall assume the liability of all the employers within the group and pay all compensation for which the employers are liable under this chapter. When the plan is adopted, the group shall furnish satisfactory proof to the Superintendent of Insurance of its financial ability to pay such compensation for the employers in the group and its revenues, their source and

assurance of continuance. The superintendent shall require the deposit with the board of such securities as the superintendent determines necessary of the kind prescribed in subsection 9 or the filing of a bond issued by a surety company authorized to transact business in this State, in an amount to be determined to secure its liability to pay the compensation of each employer as above provided in accordance with subsection 9. Such surety bond must be approved as to form by the superintendent. The superintendent may also require that any agreements, contracts and other pertinent documents relating to the organization of the employers in the group be filed with the superintendent at the time the application for group self-insurance is made. The application must be on a form prescribed by the superintendent. The superintendent has the authority to deny the application of the group to pay such compensation for failure to satisfy any applicable requirement of this section. The superintendent shall approve or disapprove an application within 90 days. The group qualifying under this paragraph is referred to as a self-insurer.

B. An employer participating in group self-insurance is not relieved from the liability for compensation prescribed by this chapter, except by the payment of the compensation by the group self-insurer or by the employer. As between the employee and the group self-insurer, notice to or knowledge of the occurrence of the injury on the part of the employer is deemed notice or knowledge, as the case may be, on the part of the group self-insurer; jurisdiction of the employer is, for the purpose of this chapter, jurisdiction of the group self-

insurer and the group self-insurer is in all things bound by and subject to the orders, findings, decisions or awards rendered against the participating employer for the payment of compensation under this chapter. The insolvency or bankruptcy of a participating employer does not relieve the group self-insurer from the payment of compensation for injuries or death sustained by an employee during the time the employer was a participant in group self-insurance. The group self-insurer shall promptly notify the Superintendent of Insurance and the board, on a prescribed form, of the addition of any participating employer or employers. The approval of the superintendent is not necessary in order to add participating employers to the group self-insurer. Notice of termination of a participating employer is not effective until at least 10 days after notice of that termination, on a prescribed form, has been filed in the offices of the superintendent and the board or sent to both offices by registered mail. The group self-insurer shall give notice of the termination of any participating member to all other participating members at least quarterly each year. Written notice must be given to any new participating member at the time of admission that the specific membership of the group and its members as prescribed in this section is not affected by the group's failure to provide its members with prior or immediate notice of changes in the membership of the group if notice is given at least quarterly, as long as the termination or admission of members was effected in compliance with all group agreements and bylaws and this section and the rules adopted pursuant to it.

C. Each group self-insurer, in its application for self-insurance, shall set forth the names and addresses of its officers, directors, trustees and general manager. Notice of any change in the officers, directors, trustees or general manager must be given to the Superintendent of Insurance and the board within 10 days of the change. An officer, director, trustee or employee of the group self-insurer may not represent or participate directly or indirectly on behalf of an injured worker or the worker's dependents in any workers' compensation proceeding. All employees of employers participating in group self-insurance are deemed to be included under the group self-insurance plan.

D. If for any reason the status of a group self-insurer under this paragraph is terminated, the securities, the surety bond, the letter of credit or the deposit required by this section continues to be held by the Treasurer of State and remains subject to the control of the board until all claims secured by the securities, surety bond, letter of credit or deposit have been discharged. When all such claims have been discharged or after such period as the Superintendent of Insurance determines proper, the superintendent may accept in lieu thereof, and for the additional purpose of securing such further and future contingent liability as may arise from prior injuries to workers and be incurred by reason of any change in the condition of such workers warranting the board making subsequent awards for payment of additional compensation, a policy of insurance furnished by the group self-insurer, its successor or assigns or other entity carrying on or liquidating such self-insurance group. The policy must be in a form approved

by the superintendent and issued by any insurance company licensed to issue this class of insurance in the State. It may only be issued for a single complete premium payment in advance by the group self-insurer. It must be given in an amount determined by the superintendent and when issued is noncancellable for any cause during the continuance of the liability secured and so covered.

E. The Superintendent of Insurance may provide for the administration of this section relating to self-insurance in the manner prescribed in Title 24-A, section 212.

F. If an employer is a partnership or a sole proprietorship and is a member of a self-insurance group associated pursuant to this section, the employer may elect to include as an employee any member of the partnership or owner of the sole proprietorship for purposes of obtaining workers' compensation coverage under this Act. In the event of such an election, the electing employer shall serve upon the group self-insurance association written notice naming the partner or sole proprietor to be covered, and an election is deemed not to have been made within this Act until such notice has been given. By making such an election, the partnership member or sole proprietor is deemed to have stipulated that for premium payment purposes the annual salary or wage of the electing partnership member or sole proprietor is the average weekly wage in the State as computed by the Bureau of Employment Security multiplied by 52 and rounded to the nearest $100. The assumed average annual wage must be adjusted

as of July 1st using the average weekly wage from the prior calendar year.

G. Fee schedules applicable to group self-insurers are those set forth in Title 24-A, section 601.

H. Each group self-insurer shall record its loss expense and experience in accordance with Title 24-A, section 2323.

I. Annual examinations of each group self-insurer, as required by the Superintendent of Insurance, must be performed by public accountants acceptable to the superintendent and reports must be rendered to the superintendent within a reasonable period, as determined by the superintendent, subsequent to the group self-insurers elected fiscal year. The examinations must be conducted pursuant to generally accepted accounting principles, as they are consistent with precepts prescribed by the superintendent, that place sound values on assets and liabilities of group self-insurers. Other examinations of the affairs, transactions, accounts, records and assets of each group self-insurer and of any person as to any matter relevant to the financial affairs of the group self-insurer must be conducted as often as the superintendent determines advisable. The expense of examination of a group self-insurer must be borne by the group that is examined.

J. In any fiscal year, a group self-insurer may not be required to obtain aggregate reinsurance with a policy limit that exceeds a multiple of 1.5 of its annual standard workers' compensation premium for that fiscal year. The Superintendent of Insurance may set lower policy limits for

aggregate reinsurance when, in the superintendent's judgment, lower limits may be prudent.

K. Upon approval by the Superintendent of Insurance, a group self-insurer may dedicate a portion of its unimpaired surplus to increase its self-insured retention level under the aggregate reinsurance policy by an amount equal to the amount of surplus so dedicated. The superintendent before granting approval shall consider among other factors:

(1) The level of alternate revenues available to the group self-insurer to cover the further assumed costs; and

(2) The adequacy of the fund's surplus to meet obligations of the group self-insurer.

At the expiration of a period of 10 calendar days after the superintendent has received a plan for the dedication of a portion of the unimpaired surplus of a group self-insurer to increase its self-insured retention level and any additional information the superintendent has determined necessary, the plan is deemed approved unless prior to the expiration of that time period it has been affirmatively approved or disapproved by the superintendent.

L. Upon the filing of a plan that meets the approval of the Superintendent of Insurance, a group self-insurer may be authorized to issue subordinated loan certificates, the proceeds of which must be made part of the group self-insurer's surplus account and be available as other surplus funds for dedication to increase the self-insured retention level. To the extent that the proceeds of these loan certificates are utilized by a group self-insurer to increase its

self-insured retention in any fiscal year, the aggregate proceeds of the loan certificates so utilized may not exceed 25% of the annual standard premium for that fiscal year. The obligation to redeem these loan certificates after the proceeds of the loan certificates have been dedicated to increase the aggregate excess self-insured retention level of the group self-insurer is subordinate to covered claims and may not be redeemed after the dedication without the approval of the superintendent.

6. **Annual renewal; actuarial evaluation.** Renewal and actuarial evaluation are governed by this subsection.

A. Any approval granted by the Superintendent of Insurance to an individual self-insurer or group self-insurer must be for a term of not more than one year. Application for renewal of approval to self-insure must be submitted to the superintendent not less than 21 days prior to the self-insurer's renewal date, except that evidence of reinsurance coverage may be submitted up to 3 working days prior to renewal. A renewal application must contain: all reports, statements and other data required to be filed annually under rules adopted by the superintendent; copies of any proposed reinsurance contracts, binders or cover notes; evidence of security posted; notice of any changes in servicing arrangements; and notice of any change in control of the self-insurer and its effect, if any, on guarantees provided pursuant to subsection 3. The superintendent may refuse to grant or renew self-insurance approval based upon any of the following grounds:

(1) Failure to submit any information that is required by law or rule or is reasonably requested by the superintendent;

(2) Failure of a self-insurer to establish that it has met all applicable requirements of law or rule;

(3) Fraud or misrepresentation in the application; or

(4) Any ground upon which approval may be suspended or revoked as provided in subsection 13.

B. Each individual self-insured employer, except those utilizing an actuarially fully funded trust pursuant to subsection 3, is required to obtain an actuarial evaluation of undischarged claims and claims settlement liabilities at least once every 3 years. This review and evaluation must be performed by a casualty actuary who is a member of the American Academy of Actuaries. Upon approval to self-insure, the Superintendent of Insurance shall indicate the deadline for that self-insurer to complete an actuarial review. In addition to this triennial review, the superintendent may require the reserves and liabilities of a self-insurer to be reviewed and evaluated as often as the superintendent determines necessary.

Any self-insurer that develops an imputed annual standard premium not exceeding $50,000 and demonstrates that it has provided security for its workers' compensation exposures in an amount that is at least 135% of its case-based claims reserves, as evaluated annually, is excused from providing an actuarial evaluation

in any year in which these conditions are satisfied. For the purposes of this subsection, "case-based claims reserves" means undischarged claims that have arisen during the period of self-insurance and of which the employer has had formal notice. This exception may not be construed to limit the superintendent's authority to require an actuarial evaluation when the superintendent determines one is necessary.

C. Each individual self-insurer except a public employer shall demonstrate in its initial or renewal application that is has working capital adequate to its operating needs.

D. When a self-insurer's reinsurance contract expires on a date other than the renewal date for its self-insurance approval, the self-insurer shall file evidence of any required reinsurance coverage no later than 3 working days before the date of expiration of its coverage.

7. **Self-insurance.** "Self-insurance," as used in this section, means the system of securing compensation as provided in subsections 2 to 16.

8. **Security deposit and reinsurance requirements for individual self-insurers.** The following security deposit and reinsurance requirements apply to individual self-insurers.

A. The bond or security deposit required of an individual self-insurer must be at least an amount determined by the following formula or $50,000, whichever is larger. The bond or security deposit must be in an amount equal to the loss and loss adjustment expense portion of the annual standard premium for the prospective fiscal coverage period or the outstanding loss

reserves minus recoveries from all excess carriers and subrogation reduced to net collections plus 25% of annual standard premiums for the prospective fiscal coverage period, whichever is larger. The percentage factor used to determine the portion of annual standard premium allocated for loss and loss adjustment expenses must be acceptable to the Superintendent of Insurance. For the purposes of this paragraph, "annual standard premium" means the annual premium produced by applying the manual rates, rating rules, excluding any premium discount, and the experience rating procedure approved by the superintendent for the Safety Pool of the residual market mechanism, as described in Title 24-A, section 2386, to the exposure and experience of the individual self-insurer.

For individual self-insurers who have a net worth equal to or in excess of $10,000,000; who have had positive net earnings demonstrated by certified statements of financial condition audited by a certified public accountant for at least 3 of the 5 latest fiscal years, including one of the 2 most recent years; and whose mean annual earnings for the 5 latest fiscal years are at least equal to the normal annual premium for the prospective fiscal coverage period, the minimum security deposit or bond must be an amount determined by the formula in this paragraph or as adjusted for applicable levels of working capital funds.

An employer meeting the standards of this paragraph may deduct from the penal value of its

surety bond or from the market value of securities deposited an amount not exceeding demonstrated working capital in such current statement of financial condition; the bond or deposit must be at least $100,000.

Self-insurers that are unable to meet the preceding standards shall deposit acceptable funds or a surety bond in that amount produced by the formula described in this paragraph written by a corporate surety that meets the qualifications prescribed by rules adopted by the superintendent.

Within 30 days after notice by the superintendent, the self-insurer shall post the deposit indicated. This deadline may be extended by the superintendent for good cause, but in no event may exceed one year from the deadline for compliance as stated in the notice given to the self-insurer.

A bond or security deposit in excess of the amount prescribed by this subsection may be required if the superintendent determines that the self-insurer has experienced a deterioration in financial condition that adversely affects the self-insurer's ability to pay expected losses.

No judgment creditor other than claimants for benefits under this Act has a right to levy upon the self-insurer's assets held in deposit pursuant to this paragraph.

B. All individual self-insurers shall maintain specific reinsurance unless the Superintendent of Insurance, in the superintendent's discretion, waives such a requirement. Specific reinsurance must generally have a limit of at least $2,000,000. Higher limits may be required for

those businesses with a high risk of multiple injury from a single occurrence. The retention underlying specific reinsurance policies must be the lowest retention generally available for businesses of similar size and exposure, but may, at the superintendent's discretion, be established at higher levels consistent with the employer's claims experience and financial condition.

All individual self-insurers shall maintain aggregate reinsurance unless the superintendent, in the superintendent's discretion, waives this requirement.

C. The Superintendent of Insurance may adopt rules establishing specific requirements applicable to security deposits and reinsurance, including, but not limited to, provisions governing standards for waiver of reinsurance, use of trusts in lieu of security deposits and release or application of deposit funds.

9. Acceptable deposit funds or surety bonds; letters of credit. In addition to cash, the deposit funds acceptable in the Superintendent of Insurance as a security deposit include United States Government bonds, notes or bills, issued or guaranteed by the United States of America; bonds secured by the full faith, credit and taxing power of political subdivisions of the United States rated in the 3 highest grades by a national rating agency such as Moody's Investors Service, Inc., Standard and Poor's Corporation or Fitch Investors Service, Inc. as of the foregoing year-end; money market funds invested only in United States Government or government agency obligations with a maturity not exceeding one year; high grade commercial paper rated as either A-1 or P-1 by a nationally recognized bond rating service such as

Moody's Investors Service, Inc., Standard and Poor's Corporation or Fitch Investors Service, Inc., or money market funds invested in such paper; certificates of deposit issued by a duly chartered commercial bank or thrift institution in the State protected by the Federal Deposit Insurance Corporation if such a bank or institution possesses assets of at least $100,000,000 and maintains a ratio of capital to assets equal to or greater than 6½%; savings certificates issued by any savings and loan association in the State protected by the Federal Savings and Loan Insurance Corporation if such an association possesses assets of at least $100,000,000 and maintains a ratio of capital to assets equal to or greater than 6½%; surety bonds in a form prescribed by the superintendent issued by any corporate surety that meets the qualifications prescribed by rule of the superintendent; irrevocable standby letters of credit issued to the Treasurer of State by financial institutions with long-term unsecured debt ratings of at least A by either Moody's Investors Service, Inc. or Standard and Poor's Corporation or with commercial paper within the 3 highest short-term rating categories established by Moody's Investors Service, Inc. or Standard and Poor's Corporation; and such other investments approved by the superintendent.

10. Form of reinsurance contracts. All reinsurance contracts issued or renewed after the effective date of this subsection must be issued by companies that meet the requirements of subsection 11 and must name the self-insurer and the Maine Self-Insurance Guarantee Association as coinsureds to the extent of their respective interests. These reinsurance contracts must recognize the Maine Self-Insurance Guarantee Association's rights of

recovery, within the terms of coverage provided by the contract, for payments made by the association to or on behalf of claimants regarding covered claims and for claims in the course of settlement, the value of which when reduced to payments will create an obligation on the part of the reinsurance carrier to reimburse the association to the extent of funds disbursed by the association to discharge covered claims. The requirements of this subsection apply to any reinsurance contract issued to any individual or group self-insurer as part of a self-insurance program approved for use within this State and are in addition to any other requirement applicable to reinsurance contracts imposed by law or rule.

Reinsurance contracts must further specify that the reinsurance carrier and the Maine Self-Insurance Guarantee Association may enter into agreements on the terms of settlement and distribution of benefits accruing to claimants within the limits of the authority of the parties to make settlements with respect to any coverage year.

To the extent that the Maine Self-Insurance Guarantee Association succeeds to a recovery of benefits from any reinsurance carrier on behalf of claimants, those benefits must be timely disbursed by the association to or on behalf of claimants as they become due and payable pursuant to this Act. Funds recovered under reinsurance contracts on behalf of claimants must be applied consistent with the terms of coverage under the contract to loss, loss adjustment expense and attorneys' fees that are payable under this Act.

11. Qualifications for reinsurance carriers. A workers' compensation contract or policy issued after the

effective date of this section may not be recognized by the Superintendent of Insurance in considering the ability of an individual or group self-insurer to fulfill its financial obligations under this Act, unless the contract or policy is issued by an admitted insurance company or a reinsurance company that meets on a continuous basis the requirements of Title 24-A, chapter 9, subchapter III[2] and the reinsurance company has been approved by the superintendent to issue in this State contracts of primary workers' compensation reinsurance, or by Lloyd's of London, a syndicate of unincorporated alien insurers that has established and maintains United States trust funds consistent with the requirements of Title 24-A, chapter 9, subchapter III. Each contract of primary workers' compensation reinsurance that is proposed for use in this State must be filed for approval in the manner set out in Title 24-A, section 2412. Insofar as is practicable, a contract so approved may be modified with less than 30 days advance filing notice if the superintendent determines the modifications suggested are not contrary to provisions of Title 24-A, section 2412, this Title or Bureau of Insurance Rule Chapter 250 and are necessary to effect required reinsurance coverage to authorize the self-insurer to operate a plan of workers' compensation self-insurance.

12. Qualifications for claims personnel. Persons who investigate, settle or negotiate the settlement of claims on behalf of self-insurers or employees of self-

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[2] 24-A M.R.S.A. § 731 et seq. (repealed; see, now, 24-A M.R.S.A. § 731-A et seq.).

insurers are required to be licensed as insurance adjusters pursuant to Title 24-A, chapter 17, subchapters I[3] and IV.[4]

13. Revocation or termination of self-insurance privilege. The following may constitute grounds for denial of the right of any individual or group to continue the option of self-insurance:

> **A.** Failure to comply with rules adopted by the Superintendent of Insurance or any provisions of this Act within 14 days of notice of such failure or such other time as may be established by order of the superintendent;
>
> **B.** Failure to comply with any lawful order of the Superintendent of Insurance;
>
> **C.** Repeated failure to comply with rules of the Superintendent of Insurance or any provisions of this Act;
>
> **D.** Committing an unfair or deceptive act or practice as defined in Title 24-A, sections 2151 to 2167;
>
> **E.** Deterioration of financial condition adversely affecting the self-insurer's ability to pay expected losses; or
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> **F.** Failure to pay any lawful assessment of the Maine Self-Insurance Guarantee Association.

Notwithstanding Title 5, section 10051, the superintendent is expressly granted the authority to revoke or suspend the right of an individual or group to continue the option to self-insure after a hearing held on not less than

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[3] 24-A M.R.S.A. § 1501 et seq.

[4] 24-A M.R.S.A. § 1801 et seq.

7 days' notice in accordance with Title 5, chapter 375, subchapter IV[5] and Title 24-A, chapter 3.[6]

14. Termination of self-insurance. If a self-insured employer elects to terminate its self-insurance program or a portion of a self-insurance program, it shall submit a termination plan to the Superintendent of Insurance at least 45 days before terminating its program. The requirements of this subsection apply to that part of the self-insurance program that is being terminated. The termination plan must specify, but is not limited to, procedures for claims handling, reservation of assets to be maintained in the State to discharge claims liabilities and other obligations under this Act, and a description of how ultimate reserves were determined that require reservation of funds. The termination plan must contain a written agreement that the self-insurer will continue to be subject to informational filings respecting financial condition and actuarial evaluations of claims and claims expense reserves and loss transfers when determined necessary by the superintendent to ensure that claims are adequately secured. The plan must also comply with any terms and conditions prescribed by rule by the superintendent. In order to protect the interests of claimants, the superintendent may require a further deposit to be held in trust by the Treasurer of State or may require full funding of workers' compensation liabilities.

If a self-insurer's approval is revoked, suspended or otherwise terminated in a manner other than by its election,

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[5] 5 M.R.S.A. § 9051 et seq.

[6] 24-A M.R.S.A. § 200 et seq.

the Superintendent of Insurance shall issue an order that prescribes terms and conditions related to the termination that must, to the extent practicable, conform to the requirements governing termination plans as prescribed by this subsection and rules adopted under this subsection. In the event that a self-insurer attempts to terminate its approval in this State without filing a plan acceptable to the superintendent, the superintendent shall issue an order prescribing the terms and conditions of the termination. Any order issued pursuant to this subsection, including an order directing a self-insurer to produce relevant information, may be enforced as provided by Title 24-A, section 214.

This subsection applies to any termination of a self-insurer's approval, whether in whole or in part, including those resulting from a business sale, split-up, spin-off, leveraged buyout, reorganization, termination of a guarantee provided under subsection 3, or cessation of business in the State.

15. Confidentiality of information. All written, printed or graphic matter or any mechanical or electronic data compilation from which information can be obtained, directly or after translation into a form susceptible of visual or aural comprehension, all information contained in the minutes of trustee meetings and all information relating to individual compensation cases, that a self-insurer is required to file with or make available to the superintendent under this section, section 404 or rules adopted pursuant to it are confidential and are not public records.

The confidential nature of this information does not limit or affect its use by the superintendent in administering this Act, including, but not limited to, communications with the service agent, the Workers' Compensation Board or the Maine Self-Insurance Guarantee Association.

16. Registration of self-insurers. Registration of self-insurers is governed as follows.

A. All employers claiming the status of self-insurer as defined by this title shall apply for registration with the Bureau of Insurance on forms prescribed by the Superintendent of Insurance. The application must contain a statement identifying the employer as a self-insurer, which includes the legal organization and name of each self-insuring employer. The superintendent may require the submission of any further information the superintendent deems necessary in order to determine whether a self-insurer has been approved pursuant to this section. If an employer is unable to establish that it has been approved to act as a self-insurer, the superintendent shall deny the application for registration. Upon denial of registration, an employer may make application for approval to act as a self-insurer in accordance with all requirements of this Act and the rules adopted pursuant to this Act.

B. On January 1st of each year, the Superintendent of Insurance shall promulgate an official list of self-insurers that are approved and registered as of that date and the list of self-insurers must be forwarded to the Maine Self-Insurance Guarantee Association. The superintendent shall add to the list at any time during the year the name or names of any self-insurer or self-

insurers the superintendent has approved and registered subsequent to the promulgation of the list and shall similarly delete the name or names of any self-insurer or self-insurers whose authority to self-insure has been terminated. Additions to or deletions from the official list of self-insurers must be forwarded to the Maine Self-Insurance Guarantee Association when made. Failure to become registered pursuant to this subsection terminates an employer's authority to self-insure under this Act.

* * *

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MAINE INSURANCE RULE CHAPTER 560
WORKERS COMPENSATION INSURANCE – EMPLOYEE LEASING

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Section 1. Purpose

The purpose of this rule is to ensure that an employer who leases some or all of its workers properly obtains workers' compensation insurance coverage for all of its employees, including those leased from another entity,

and that premium commensurate with exposure and anticipated claim experience is paid.

Section 2. Authority

This rule is promulgated pursuant to 24-A M.R.S.A. §§ 212, 2178, 2364, and 2366 and 32 M.R.S.A. § 14055(2).

Section 3. Definitions

A. "Employee leasing arrangement" means an arrangement, under contract or otherwise, whereby one business or other entity leases all or a significant number of its workers from another business. Employee leasing arrangements include, but are not limited to, full service employee leasing arrangements, long-term temporary arrangements, and any other arrangement which involves the allocation of employment responsibilities among two or more entities. For purposes of this rule employee leasing arrangement does not include arrangements whereby an organization hires its own employees and assigns them to clients for a finite period of time to support or supplement the client's work force in special work situations such as employee absences, temporary skill shortages and seasonal workloads.

B. "Leased employee" means a person performing services for a lessee under an employee leasing arrangement.

C. "Lessee" means an entity which obtains all or part of its work force from another entity

through an employee leasing arrangement or which employs the services of an entity through an employee leasing arrangement.

D. "Lessor" means an entity that grants an oral or written lease to a lessee through an employee leasing arrangement. In this rule, the lessor may also be referred to as an employee leasing company.

E. "Multiple coordinated policies basis" means:

(1) (a) Each lessee shall have its own policy covering its leased employees required to be covered pursuant to the laws of this state;

(b) If non-leased employees of a lessee are not provided coverage pursuant to a separate policy or pursuant to 39 M.R.S.A. § 23, subsections 2 thru 11, they shall be included on the policy required by subsection (a) above; and

(2) All assigned risk policies for lessees of the same employee leasing company shall be assigned to one servicing carrier in the state and in other states to the extent possible; and

(3) The servicing carrier shall arrange to have the same renewal date for all such policies; and

(4) The servicing carrier shall arrange to have all notices sent to the employee leasing company and to have a single master invoice sent to the employee leasing company for all policies covering the lessees of that leasing company.

(5) If a lessee leases employees from more than one lessor, there shall be a separate policy for the leased employees of each lessor.

(6) The servicing carrier also shall issue a policy covering the internal employees of the employee leasing company unless they are otherwise covered.

(7) Appropriate endorsements need to be used to restrict the coverage to those employees of the lessor leased to the lessee which is the subject of each policy as opposed to other lessees and to coordinate coverage between lessees and lessor.

F. "Premium Subject to Dispute"

Premium shall be considered subject to dispute only if the insured has provided a written notice of dispute to the insurer or service carrier, has filed a written request for an administrative hearing or a hearing before the committee having authority to review premium disputes, or has initiated litigation regarding the premium dispute. The insured must have detailed the specific areas of dispute and, to the extent possible, provided an estimate of the premium the insured believes to be correct. The insured must have paid any undisputed portion of the bill.

Section 4. Eligibility for Policy Issuance and Continuance

A. Basic Rule.

Except as provided in Subsection B, a lessee, not authorized to self-insure pursuant to 39 M.R.S.A. § 23, shall fulfill its statutory responsibility to secure benefits under the Workers' Compensation Act by purchasing and maintaining a standard workers' compensation policy approved by the Superintendent of Insurance. The exposure and experience of the lessee shall be used in determining the premium for policy.

B. Exceptions

A lessor which obtains coverage in the voluntary workers' compensation market and is registered with the Superintendent of Insurance, pursuant to 32 M.R.S.A. § 14052, may, with the voluntary market insurer's knowledge and consent, elect to secure the coverage on leased employees through a standard workers' compensation policy issued to the lessor. The insurer of the lessor may take all reasonable steps to ascertain exposure under the policy and collect the appropriate premium through the following procedures:

(1) Complete description of lessor's operations;

(2) Periodic reporting of covered lessee's payroll, classifications, experience rating modification factors, and jurisdictions with exposure. This reporting may be supplemented by a requirement to submit to the carrier Internal

Revenue Service Form 941 or equivalent form on a quarterly basis.

(3) Audit of lessor's operations; and

(4) Any other reasonable measures to determine the appropriate premium.

C. Residual Market Coverage.

A lessor which obtains coverage through the residual market established pursuant to 24-A M.R.S.A. § 2366 must secure coverage on a multiple coordinated policies basis. This requirement applies to all policies issued or renewed, any applications submitted, and any lessees entering into an employee leasing agreement on or after the effective date of this rule. In order to qualify for coverage on a multiple coordinated policies basis, the lessor shall meet each of the following requirements at application and at annual renewal:

(1) Its officers or directors, or any person with a five percent (5%) or greater interest does not owe any premium to the current or prior insurers, except premium subject to dispute; and

(2) Provide such information as is otherwise required by this rule; and

(3) Be registered as an employee leasing arrangement with the Bureau of Insurance.

D. Application data required for residual market.

A lessor which applies for coverage through the residual market shall furnish

the following information with the application for coverage:

(1.) A list by jurisdiction of each and every name that the employee leasing company has operated under in the preceding five (5) years (including any alternative names and names of predecessors, and successor business entities) along with the policy number and carrier for each workers' compensation insurance policy issued to the employee leasing company under each and every such name in the preceding five (5) years and a copy of the most recent Form 941 filed with the United States Internal Revenue Service by the employee leasing company;

(2.) A list of each and every person or entity who owns a five percent (5%) or greater interest in the employee leasing business at the time of application and a list of each and every person or entity who formerly owned a five percent (5%) or greater interest in the employee leasing company or its predecessors, successors, or alter egos in the preceding five (5) years;

(3.) For each person or entity identified in the preceding subsection, a list of all other employee leasing companies in which such person or entity owns or owned a five percent (5) or greater interest and a list of all other businesses in which such person or entity owns or owned a fifty percent (50%)

or greater interest at the time application is made and in the preceding twelve (12) months;

(4.) The Internal Revenue Service Form 941 or equivalent most recently filed with the service with respect to each lessee and a copy of the most recent Form 941 or equivalent filed with the United States Internal Revenue Service by each lessee.

(5.) A sworn written statement signed by the owner, partner or officer authorized to bind the lessee legally, that states the policy number and carrier for each workers' compensation insurance policy issued to the lessee under each and every such name in the preceding five (5) years;

(6.) The employee leasing company must also furnish for each lessee at the time of application or renewal; a listing of all leased employees along with their social security number, classification code and wages; and

(7.) A sworn written statement signed by the owner, partner or officer authorized to bind the lessee legally that states that all of the lessee's non-leased employees are covered by a workers' compensation insurance policy. In addition, the affidavit must provide the policy number, carrier, a listing of the number of non-leased employees, and the aggregate payroll applicable to each classification code.

A lessor which applies for coverage through more than one residual market policy at one time needs only to furnish one copy of the information required by paragraphs (1) to (3), above. A lessor which applies for coverage through the residual market pursuant to policies to be coordinated with other policies already in force and with respect to which the information required by paragraphs (1) to (3), above, has been provided previously, shall be required only to provide such information as is necessary to update the previously provided information. With respect to unchanged information, a lessor may make reference to its' [sic] previous submissions.

E. Other data required.

A lessor which applies for coverage or is covered through either the voluntary market or the residual market mechanism shall also maintain and furnish to the insurer or to the principal rating organization through the residual market servicing carrier sufficient information to permit the calculation of an experience modification factor for each lessee. Such information shall include:

(1.) The lessee's corporate nameor [sic] operating name if the lessee is not a corporation;

(2.) The lessee's taxpayer or employer identification number;

(3.) The lessee's risk identification number;

(4.) A listing of all leased employees associated with each lessee, the applicable classification code and payroll; and

(5.) Claims information grouped by lessee, and any other information necessary to permit the calculation of an experience modification factor for each lessee.

Section 5. Policy Cancellation or Nonrenewal

A. Grounds for Cancellation and Nonrenewal.

In addition to any statutory grounds that may exist, any violation of this rule is grounds for cancellation or nonrenewal provided that the employee leasing company or, if appropriate, the lessee, has been provided a reasonable opportunity to cure the violation.

B. Notice to Lessees.

If an employee leasing company has received notice that its workers' compensation insurance policy issued on a master policy basis will be canceled or nonrenewed, the leasing company shall notify by certified mail, within fifteen (15) days of the receipt of the notice, all of the lessees for which there is an employee leasing arrangement covered under the to-be-canceled policy.

If one or more workers compensation insurance policies issued with respect to one or more lessees are to be canceled or nonrenewed, the insurer or service carrier shall

give any required notice to the lessor and to each affected lessee.

C. Experience Modification Factor Following Termination.

(1) Lessee covered on a multiple coordinated basis.

In the event that an employee leasing arrangement with a lessee is terminated, the lessee shall be assigned an experience modification factor which relects [sic] its experience during the experience period specified by the approved experience rating plan, including, if applicable, experience incurred for leased employees under the employee leasing arrangements.

(2) Lessee covered on a master policy basis.

In the event that an employee leasing arrangement with a lessee is terminated and the experience of the lessee is commingled with that of other clients on a lessors [sic] master policy, then the experience of the lessee shall be developed and reported by the insurer, to the extent possible, for use in development of an experience modification factor for the lessee. If suitable payroll and loss experience is not reported, then the lessors experience modification factor will apply to the lessee for up to three years (3) or until such time as the lessee qualifies for development of its own experience modification factor.

(3) Notice Required

An employee leasing company shall notify its insurer or service carrier 30 days prior to the effective date of termination or immediately upon notification of cancellation by a lessee of an employee leasing arrangement with a lessee in order to allow sufficient time to calculate an experience modification factor for the lessee.

Section 6. Lessee's Obligation

A. Nothing in this rule shall have any effect on the statutory obligation, if any, of a lessee to secure workers' compensation coverage for employees not provided, supplied, or maintained by a lessor pursuant to employee leasing arrangement.

B. (1) A lessee shall not be eligible for coverage pursuant to a workers [sic] compensation insurance policy issued to a lessor if the lessee owes its current or a prior insurer any premium for workers' compensation insurance, except premium subject to dispute.

(2) A lessee shall not be eligible for coverage pursuant to a workers' compensation policy under a multiple coordinated policy basis in the residual market if the lessee owes its current or a prior insurer any premium for workers' compensation insurance except premium subject to dispute.

Section 7. Insurer or Service Carrier Audit

All insurers shall audit any policy issued pursuant to Section 4 of this rule within 90 days of the policy effective date and may conduct quarterly audits thereafter. The purpose of the audit will be to determine whether all classifications, experience modification factors, and estimated payroll utilized with respect to the development of the premium charged to the lessor are appropriate. An audit conducted pursuant to this section does not prevent or relieve an insurer of any other audit right or responsibility it may have.

Section 8. Premium Discounts

Every insurer which issues workers [sic] compensation insurance policies on either a master policy or a multiple coordinated policy basis which provide coverage with respect to employees subject to an employee leasing arrangement shall file for approval with the Bureau a premium discount schedule applicable to such policies which appropriately reflects cost savings created for the insurer any such arrangements.

The rating bureau which files rates with respect to the residual market mechanism shall file for approval with the Bureau a premium discount schedule applicable to policies issued on a multiple coordinated basis through the residual market to lessors and/or lessees under employee leasing arrangements which appropriately reflect cost savings created for the residual market and for service carriers by any such arrangements.

Section 9. Penalties

In addition to any adjustment in premiums, the Superintendent may impose penalties upon a lessor or lessee as provided under 24-A M.R.S.A. § 12-A in any case in which a violation of this regulation or applicable statute has occurred.

Section 10. Effective Date

The effective date of this rule is October 1, 1992. This rule applies to all policies issued or renewed and any applications submitted on or after the effective date of this rule. Policies issued in the residual market pursuant to which coverage is extended to more than one lessee of a lessor pursuant to a master policy concept may remain in effect until their renewal dates, but in the event a lessor enters into an employee leasing arrangement with any client on or after the effective date of this rule, the provisions of this rule relating to multiple policies will be applicable.

STATEMENT OF BASIS OF ADOPTED RULE

There is a long administrative history underlying this adopted rule. The Bureau of Insurance response to the comments received regarding the most recent specific version of a proposed rule is influenced by the associated history. In the mid to late 1980's employee leasing companies began substantial operations both in Maine and in

other states. The introduction of these new business entities created issues regarding the application of a number of laws and rules to those firms and their clients and regarding the permissible interaction of other businesses and institutions with them. With respect to workers [sic] compensation insurance issues, the National Association of Insurance Commissioners (NAIC), after several years of work by its' [sic] Workers [sic] Compensation Task Force developed a Model Act and a Model Regulation. The Maine Superintendent of Insurance was chair of the NAIC Task Force for much of the time the rule was under consideration and was also the co-chair of a joint Task Force formed by the NAIC and the International Association of Industrial Boards and Commissions which made recommendations to the NAIC Task Force on the subject.

While the above was happening, relevant events were also occuring in Maine. Proposed rules relating to workers [sic] compensation insurance with respect to employee leasing arrangements were issued by the Maine Bureau of Insurance in both 1990 and 1991. Those proposals were considered contemporaneously with the work of the NAIC and IIABC. Some commentators and interest groups made comments both in Maine and nationally. There were also local interests who commented only on the Maine proposals. The current proposed rule is a continuation of the process and reflects many of the ultimate determinations of the NAIC and the lessons learned by the Bureau during prior Maine proceedings.

In 1991, the First Regular Session of the 115th Legislature enacted 1991 Public Law Chapter 468, An Act to Require that Employee Leasing Companies Register with

the State and to Amend the Employment Security Law. This law, in part pertinent to this rule, clarifies that if either an employee leasing company or a client company of an employee leasing company has secured the payment of compensation in conformity with the Workers [sic] Compensation Act, the immunity from liability described in that Act extends to and is binding on the client company, the employee leasing company, all employees leased to any client company and any other employees of the employee leasing company or the client company. In effect, the Legislature institutionalized the so-called "dual employer theory" which had been previously espoused by some business planners and advisers. The Legislature then left to this office to make through rulemaking various determinations relating to under what circumstances and conditions workers [sic] compensation insurance policies could be issued.

Through all the above proceedings, this office has attempted to act in such a manner as to develop a regulatory response to the somewhat unique questions posed by employee leasing which (1) clarifies permissible activities and relationships so that professionals may properly and safely advise their clients, (2) protects the integrity of the workers [sic] compensation classification and rating processes against certain possible abuses presented by employee leasing arrangements, and (3) attempts to accomodate [sic] and balance the sometimes conflicting needs and interests of sectors of the business community in the least obtrusive manner consistent with sound public policy.

The remainder of this Basis Statement responds to the comments received with respect to the specific proposal under consideration.

The National Association of Temporary Services suggested deletion of references in the rule to "temporary help services" from Section 3(A). It convincingly discussed why the intent of the provision in which the reference was contained is maintained absent the reference, a change has been made.

Comments made on behalf of The Hanover Insurance Company state " . . . it might be helpful to require the carrier who provides the multiple coordinated policies to also provide the policy to the employee leasing company for its own non-leased employees. Presumably this will help for purposes of accurate premium computation." The Bureau believes that this provision is already included as Section 3(A)(6) of the rule and therefore no change is made to the proposal on this point.

The National Council on Compensation Insurance commented that the intended application of experience rating modification factors to employee leasing arrangements in the proposed rule was not as clear as it might be and not as clearly stated as in the National Association of Insurance Commissioners (NAIC) Model Employee Leasing Regulation. A new section 5(C)(1) has been added to improve clarity.

A question was raised by Becky Coleman as to what provisions were contemplated for the transition of any employee leasing arrangements which now held master policies to the multiple coordinated policy system. Appropriate language was added to Sections 4(C) and 10

to clarify that existing master policies in the residual market, if any, are to be rewritten on a multiple coordinated basis at the renewal date of the master policy. In order to provide for equity among leasing companies, any new clients added by an employee leasing company on or after the effective date of the rule must be written on the multiple policy basis.

Combined Management Inc.'s comments raised a question regarding the process for handling presumably new clients of employee leasing companies that owe back workers' compensation payments to prior carriers. It asserts a need for those firms to maintain coverage with their prior carriers. The Bureau partially agrees. Pursuant to provisions of law other than the proposal, workers [sic] compensation insurance policyholders who are delinquent with respect to premiums not in dispute are subject to cancellation of coverage. Furthermore these policyholders are not eligible to secure further coverage through the residual market mechanism until past debts are satisfied. Therefore Combined Management is correct that delinquent policyholders, to the extent they can avoid cancellation, need to remain with their prior carriers until they have become current on their premium obligations. To that extent, whether or not such firms have entered into an employee leasing arrangement in the meantime becomes an irrelevant consideration. Combined Management continues its' [sic] comment by suggesting that once a delinquent firm which has entered into an employee leasing arrangement becomes current on its prior obligations, it should be able to be reassigned to the carrier servicing the multiple coordinated policies withour [sic] having to reapply or pay a surcharge. The

Bureau's view is that at such time as the prior debt is satisfied, that the firm is then in [sic] essentially in the same posture as other businesses which have entered into leasing arrangements and should not be treated differently. No special provision has been included in the rule to deal with this situation.

Combined Management, Inc. also notes that the proposed rule does not "direct rates for policies to reflect or offer a safety discount." It is not clear to the Bureau what is meant by this comment. If the suggestion is that employee leasing companies are entitled to a recognition not available to other employers based on safety considerations, no basis has been demonstrated. If the comment is made in reference to the workplace safety programs contemplated by either 24-A M.R.S.A. §§ 2362-B(2), 2366(5)(C), or 2366(7)(A), those programs will be the subject of other proposed rules which the Bureau anticipates issuing in the near future.

Section 3(E)(3) of the rule provides for the servicing carrier to arrange to have the same renewal date for all multiple coordinated policies issued to clients of a leasing company. This common renewal date is one of the aspects of the system intended to make life easier for employee leasing companies. The leasing industry had previously raised concern that multiple policies, if not coordinated, would cause leasing company operations to be extremely disrupted through having to deal continually with a succession of policies, carriers, and company personnel. Combined Management, Inc., however, questions how this can be done when leasing clients apply for coverage on different dates. The answer is that the residual market plan in use already provides for and can accomodate [sic]

short term policy periods. This essentially involves utilization of a partial year of experience in the experience rating calculations. The Bureau anticipates that service carriers will utilize these when a new client enters into a leasing arrangement. Combined Management further questions the cost impact on clients of changing renewal dates. The Bureau's understanding is that it could cut either way depending on an individual firm's claims history. Usage of a partial year may cause a time period when there was either positive or adverse claims experience to have either a greater or lesser impact than it otherwise would have. The net impact on a system wide basis, however, should be zero.

A representative of the Independent Insurance Agents of Maine raised a series of questions regarding the interaction of employer's liability insurance, general liability insurance, and worker's [sic] compensation insurance with regard to employee leasing companies and their clients. These questions generally require a consideration of the wording and intent of 32 M.R.S.A. § 140[illegible] in light of the nature of the various coverages. The Bureau believes that some of the issue may be raised by the dual narrow and generic meanings sometimes ascribed to the term "employer's liability". Employers liability coverage is a relatively narrow coverage which is part and parcel of coverage provided under the standard workers [sic] compensation policy. If the Bureau is not mistaken, this coverage will remain and its protections run to the benefit of both the leasing company and its clients. We do not believe that the Legislature by enacting both sub-§§ (1)(B) and(4) of 32 M.R.S.A. intended to bifurcate the underlying coverage. Commercial general

liability coverages standardly contain coverage exclusions for employer liabilities to employees. It is our general understanding that this is intended to allow the general liability policy to exclude claims properly covered under the Workers [sic] Compensation Act and policy.

In the situation where the client of a leasing company has purchased its own general liability coverage and has secured workers [sic] compensation coverage (which includes employers liability coverage) in compliance with Title 39, the Bureau does not see the gap in coverage Mr. Candage describes. With respect to the leasing company itself, to the extent that sub-§ (4) of § 14055 controls, the Bureau can see where there may be an arguable need for the leasing company to purchase a general liability policy as well as be covered under a worker's [sic] compensation insurance policy to protect itself against the claims of injured workers. In either case, the issue would appear to be one of statutory interpretation not to be resolved through this rule.

Comments made on behalf of Atlantic Staff Management, recommended that Maine not adopt the multiple coordinated policy approach which is the centerpiece of this rule, but instead utilize the approach wherein a master policy would be issued to an employee leasing company which provides coverage for all its employees. This is presented as an approach less burdensome to employee leasing companies. Both of the previously proposed versions of Rule Chapter 560 which had been the subject of hearings conducted by this office had utilized the master policy approach. Comments critical of that approach as well had been made at the earlier hearings which brought

forth problems with using the approach in Maine. The principal problem is that Maine has enacted over the last several years statutory premium surcharges for employers insured through the residual market which maintain unsafe workplaces as measured by experience modification factors. There was not apparent, under the master policy concept, a feasible way to maintain appropriate administration of the surcharges. Additionally, the former Superintendent of Insurance, in his capacity as Chair of the NAIC Workers [sic] Compensation Task Force had been advocating the master policy approach. This approach was eventually rejected by the Task Force and by the NAIC. The Bureau believes it unlikely to be widely adopted in other jurisdictions.

At this point, the Bureau believes that the multiple coordinated policy approach represents a fair and workable compromise position between those interests in favor of the master policy approach and those who would prefer other alternatives. The invitation to return to the master policy approach is declined.

Atlantic Staff Management's second comment is that the proposed rule places regulatory burdens on the leasing industry far beyond those necessary for administration of the multiple coordinated policy approach. This view was seconded by Michael Peterson of Combined Management.

Atlantic's first specific over-regulation concern relates to Section 3(E)(7) of the proposal. The Bureau believes the concern arises due to the ambiguousness of that provision. The purpose of the "appropriate endorsement" requirement is to identify the workforce covered

under each multiple coordinated policy. In light of the "dual employer" status accorded employee leasing arrangements in Maine, the persons covered under a policy issued to a client which is to be coordinated with policies issued to other clients may cover all or some of employees leased to that client but will inherently cover only a subset of the leasing company's total workforce. It is not the Bureau's intent to require leasing companies and service carriers to engage in a neverending quest to continually issue endorsements listing the names of employees covered under each policy. The intent is only to identify the persons covered under each policy. Accordingly, the reference to "specific employees" has been deleted and replaced with language hopefully more indicative of intent.

Atlantic states that Paragraphs 1-3 of Section 4(D) should be deleted as they are either duplicative of information submitted by a leasing company upon registration with the State or unrelated to the insurance industry's task. The information contained in a leasing company's state registration filing is not inappropriate to require in a residual market application as well as neither the residual market manager nor the service carrier to be assigned are possessed of the state filing. The Bureau also believes that, given the potential systematic abuses to be protected against, the information is not unrelated to the responsibilities of those administering Maine's residual market. Upon consideration of Atlantic's comments, however, it is concluded that the information required by Paragraphs 1 to 3 constitutes a greater burden than appears reasonably necessary. A lessor applying for coverage will be doing so either with respect to its own non-leased employees or

with respect to employees to be covered under one of several multiple coordinated policies issued with respect to clients. Applications for several separate policies may be made simultaneously or separately. If made simultaneously, it is overly burdensome to require that all the required information be included with each application. If made separately, it seems sufficient to require only an "update" of previously filed information. A new paragraph reflective of these comments has been added at the end of subsection 4(D).

The Bureau disagrees with Atlantic's comments regarding paragraph 4(D)(4). This provision is intended to provide a mechanism to control abusive understatements of payroll by providing for filing of Form 941s which would be inclusive of both leased and non-leased payroll of applicable to a lessee. No change is made.

The Bureau disagrees with both of Atlantic's comments regarding Section 4(E). The information required here is necessary to allow premium auditor's [sic] to develop experience modification factors and is necessary in both the residual and voluntary markets. No change is made.

Atlantic's comments regarding the need for clarification of Section 5 of the proposal are well-taken. Ambiguities in this provision appear to stem from the conversion to the multiple coordinated policy approach from the master policy approach contained in earlier proposals. New wording has been added to clarify and to address Atlantic's concerns regarding the distinction in performace [sic] obligations appropriately placed on leasing companies as opposed to their clients.

The last paragraph of Section 5(C) has been redesignated as paragraph 3 in order to clarify that it is not intended to be part of paragraph 2. Its' [sic] provisions are applicable to both the voluntary and residual market.

Atlantic also submitted a comment concerning Section 6(B)(2) suggesting that if that provision is retained, it should pertain to all employers and not just clients of employee leasing companies. The requirement in question is otherwise made applicable to other employers by Maine Insurance Rule Chapter 440, Subchapter III, Section 1(D). The purpose of the provision in this rule is simply to address the underlying issue in the unique context of the dual employer status of employee leasing companies and their clients. No change is made to the proposal in this area.

Atlantic's last comment advocates implementation of a premium discount applicable to employee leasing arrangements and provides several examples of efficiencies of administration and other savings created for insurers by employee leasing arrangements. The comment is well taken. The amount of any discount which might be appropriate at any point in time is a rating issue. The proposal has been amended by a new Section 8 which requires the rating organization to make a filing establishing a premium discount schedule applicable to policies issued with respect to employee leasing arrangements. Subsequent sections of the proposed rule have been renumbered accordingly.

An effective date of October 1, 1992 has been added.